DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LICENSING PROGRAMS

TECHNICAL ASSISTANCE
FOR
LICENSING STAFF

On
Assisted Living Facility Regulations
Effective: March 28, 2003

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DEPARTMENT OF SOCIAL SERVICES
DIVISION OF LICENSING PROGRAMS

REFERENCE CHART FOR CHANGES IN STANDARD NUMBERS FOR TECHNICAL ASSISTANCE FOR LICENSING STAFF ON ASSISTED LIVING FACILITY REGULATIONS

Old Standard # under 3/28/03 regulations	**New Standard # under 12/28/05 regulations**
60 K 2	60 M 2
150 Q	150 R
150 R	150 S
150 S 16	150 T 16
150 T	150 U
150 X	150 Y
150 Y	150 Z
400 A	400 B
400 C	400 G
400 D	400 H
400 D 1	400 H 1
400 D 2	400 H 2
400 D 4	400 H 4
400 F	400 L
400 F 2	400 L 2
400 F 12	400 L 14
400 H	400 N
400 H 1	400 N 1
400 H 2	400 N 2
400 H 3	400 N 3
400 I	400 R
400 I 2	400 R 2
630 C 4	630 C 5
700 C 22	700 C 21

NOTE: Only those standards for which TA previously existed **and** that changed in the emergency regulations are listed above.

Standard 10

Question: Are CNAs considered licensed (under the definition of licensed health care professional) since they are now licensed by the State Board of Nursing?

Answer: No. CNAs are certified by the State Board of Nursing, not licensed. They are not considered licensed health care professionals.

Question: Can a licensed nursing home administrator be a licensed health care professional for purposes of the ALF regulations?

Answer: No. While nursing home administrators are licensed, the emphasis is more on administration than direct care. They are not considered a health care professional for purposes of the ALF regulations.

Question: Is the definition of restraint in the ALF regulations the same as the definition that Virginia uses in licensed nursing home settings?

Answer: The definition of physical restraint is the same in the ALF regulation and the proposed nursing home regulation; the definition of chemical restraint differs somewhat. In the ALF regulations chemical restraint "means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident's medical symptoms, including when the drug is used in one or more of the following ways: 1. In excessive dose (including duplicate drug therapy); 2. For excessive duration; 3. Without adequate monitoring; 4. Without adequate indications for its use; 5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; and 6. In a manner that results in a decline in the resident's functional status." In the proposed nursing home regulations chemical restraint "means a psychopharmacologic drug (a drug prescribed to control mood, mental status, or behavior) that is used for discipline or convenience and not required to treat medical symptoms or symptoms from mental illness or mental retardation that prohibit an individual from reaching his highest level of functioning."

Question: The level of care criteria handout is not reflective of the actual regulations. Criteria for residential living in the regulation states that an individual may have "at least one" of the following. This implies they may meet more than one of the criteria. The handout implies they can only meet one. Is the handout wrong or misleading?

Answer: The handout is incorrect regarding the instrumental activities of daily living. Rather than specifying " 1 Instrumental Activity of Daily Living," the handout should have specified "l or more Instrumental Activities of Daily Living." The definition of residential living care in the ALF regulation states that the adults "...require only minimal assistance with the activities of daily living." Minimal assistance in defined in the regulation as "...dependency in only one activity of daily living or dependency in one or more of the instrumental activities of daily living ...."

Question: If a private pay resident who lives in a licensed apartment has outside staff (agency other than ALF staff) provide assistance, are they still considered as assisted on the UAI?

Answer: Yes. Identified need remains the same, no matter who provides assistance to meet it.

Standard 10 (continued)

Question: Can care that is provided by outside staff or a family member or spouse allow a person to be considered as independent or of a lesser assistance level (as far as their UAI status in the ALF is concerned)? Or must the person move out regardless of his ability/desire to bring in outside services/support?

Answer: Yes, their UAI would show that they need assistance, but they do not need to move out if licensed for assisted living care.

Question: Ambulatory? Does a person independent in wheelchair mobility (ex. motorized wheelchair) meet the standard for ability to exit facility during an emergency when facility is a high rise with elevators?

Answer: No.

Question: Is the definition of restraint written anywhere in this document?

Answer: See definition of physical restraint in the definition section.

October 1998

Standard 10 (Personal Representative)

Question: Can the licensee or administrator, who has not been appointed guardian or conservator, be the personal representative for residents in an assisted living facility? If so, is it acceptable for residents to routinely sign a statement on the agreement that they want the licensee or administrator to be their personal representative? And can the licensee or administrator, as the personal representative, handle the resident's financial affairs, make decisions about continued placement, and sit in on complaint interviews with the resident by licensing staff?

Answer: The intended purpose of the personal representative to be an advocate for the resident, different and separate from the facility, is expressed in both law and regulation. Having the personal representative be the licensee or administrator presents a conflict of interest. It is not acceptable for the licensee or administrator to seek to become the resident's personal representative. The licensee or administrator may only be the resident's personal representative when there is no one else available to perform such a function, in other words only as a last resort, and when the resident expressly requests such and so names the licensee or administrator.

It is not acceptable for residents to routinely sign a statement on the agreement that they want the licensee or administrator to be their personal representative.

Being a personal representative is not sufficient to establish responsibility for handling the resident's financial affairs. Nor does being a personal representative give the licensee or administrator the right to make decisions regarding continued placement in an assisted living facility. Moreover, being a personal representative does not mean that the licensee or administrator has the right to sit in on complaint interviews. Licensing staff may determine that it is not appropriate for a personal representative who represents the facility as well as the resident to be present during a complaint interview with the resident. If needed, the long-term care ombudsman or another person may be asked to be present during the interview.

October 2001

Standard 10

Question: In the definition of assisted living facility, what does "provides no more than basic coordination of care services," mean?

Answer: This issue requires further research. If the Licensing Office encounters one of these situations before guidance is issued, Central Office will provide guidance on a case by case basis.

Standard 30.B

Question: How is intensive assisted living determined for homes and by whom?

Answer: The need for intensive assisted living services is determined on the Uniform Assessment Instrument, which is completed by those allowed to do so by regulation. A resident who is assessed for intensive assisted living is dependent in four or more ADLs, or is dependent in two or more ADLs and has dependencies or semi-dependencies in a combination of behavior and orientation, or is semi-dependent in two or more ADLs and has dependencies in a combination of behavior and orientation. A resident who is assessed as needing intensive assisted living services may only reside in a facility that is licensed for the assisted living level of care, i.e., a facility that is licensed for residential and assisted living by the Department of Social Services. There are only two levels of licensure; a facility is licensed for either residential living or residential and assisted living. There is no level of licensure specific for intensive assisted living.

Question: What is the difference in nursing home care and intensive assisted living? How is this determined?

Answer: The proposed nursing home regulations define nursing home as "...any facility or any identifiable component of any facility, as defined in Section 32.1-123(2) of the Code of Virginia, in which the primary function is the provision, on a continuous basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals over a period exceeding 24 hours." Direct resident care duties are not to be performed by non-nursing employees. Every nursing home must have a fulltime director of nursing to supervise the delivery of nursing services. This person must be a registered nurse licensed by the Virginia Board of Nursing. A charge nurse must be assigned to each shift. Residents of nursing homes have medical conditions which require ongoing medical or nursing management. Functional dependency alone is not sufficient to demonstrate the need for nursing facility care or placement.

Assisted living facilities are not allowed to admit or retain individuals who require continuous licensed nursing care, which is one of the care needs prohibited in ALFs. Continuous licensed nursing care is defined in the ALF regulation as "... around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatments provided by a licensed nurse. Residents requiring continuous licensed nursing care may include: 1. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or 2. Individuals with a health care condition with a high potential for medical instability." Nursing homes and hospitals care for individuals who require continuous licensed nursing care. The ALF regulation does not require nursing staff except for specific circumstances.

Intensive assisted living services may be provided in ALFs licensed for the assisted living level of care. A resident assessed for intensive assisted living has functional dependencies as defined in DMAS regulations. The resident may meet DMAS pre-nursing facility criteria which means he meets the functional dependencies but does not have medical or nursing needs. Or the resident may meet DMAS nursing facility criteria, but does not have one of the "prohibited" conditions or care needs that are specified in the ALF regulations. In the latter case, the resident would be eligible to reside in either an ALF or a nursing home.

The UAI is used to assess the need for ALF care and the appropriate level of service for all ALF residents and the need for nursing home care for Medicaid eligible nursing home residents. Upon admission to a

nursing home, all residents are assessed by nursing home staff with a federally required comprehensive assessment called the Minimum Data Set.

Standard 60.B

Question: Will there ever be a requirement for the ALF administrators to be licensed?

Answer: There are no plans for the ALF administrators to be licensed.

Standard 60.E

Question: Does the fact that a licensee has limited power of attorney for medical decisions constitute noncompliance with this standard?

Answer: No; this is a separate issue. If a licensee has been legally granted limited power of attorney he has the authority to carry out the designated responsibility that the power gives him. The intent of Standard 60.E is to prohibit a licensee/operator, residence administrator, relative of the licensee/operator or administrator, or residence employees from becoming the conservator or guardian for a resident unless legally appointed to do so by a court of competent jurisdiction.

Standard 60.H

Question: Is an assistant administrator grandfathered?

Answer: Yes.

Standard 60.J

Question: Do the 5 hours of training if there are mentally impaired residents refer to residents who have some level of dementia or residents with a MH diagnosis and/or diagnosis of dementia?

Answer: The 5 hours of training annually are needed by an administrator of a facility where residents are mentally impaired (have any disability which reduces their ability to reason or make decisions). These would include primarily MH or MR diagnoses, but could also include diagnoses of cognitive deficits. The assisted living care requirements include additional one-time-only training requirements for administrators if the facility cares for residents with serious cognitive impairments.

Question: Where will the training for administrators required by this standard be offered to meet the 20 hour requirement?

Answer: One source would be Department-sponsored through provider fees. Training may also be available through community colleges. Facilities need to identify their own sources in addition to the above.

Question: Licensed nursing home administrators are required to get a certain number of CEUs annually to be recertified. Would these hours count toward the training requirement?

Answer: Yes.

October 2001

Standard 60.K.2

Question: If the ALF has a single administrator for both nursing home and ALF, does the manager also have to meet administrator qualifications?

Answer: No, but the manager does need to meet the qualifications and requirements of 60.L

Question: How will inspectors determine if the administrator does not provide direct management?

Answer: The administrator is not providing direct management if he is unable to demonstrate that he is meeting the requirements of 60 G in overseeing the day-to-day operation of the facility.

December 2001

Standard 60.C

Question: The current nursing home regulation requires a full-time administrator and defines full-time as 35 hours per week. That leaves 5 hours for oversight of the ALF. Is that the intention of the new law?

Answer: The law/standard allows a single licensed nursing home administrator to simultaneously oversee the operations of both the nursing facility and the assisted living facility if both are part of the same building. 22 VAC 40-71-60 H requires an administrator on the premises of the assisted living facility 40 hours per week. 22 VAC 40-71-60 K 1 requires facilities with a shared administrator to have a written management plan that includes policies and procedures describing how the administrator will oversee the care and supervision of the residents and the day-to-day operation of the facility.

Question: If buildings were connected by a walkway, would they be considered one building?

Answer: No, 22 VAC 40-71-10 defines building as a structure with exterior walls under one roof.

Question: Does the administrator of an assisted living or nursing home unit have to have the title of administrator or can she be a director of nurses in charge of the nursing home or assistant director of nurses in charge of the assisted living unit?

Answer: The facility must have an administrator of record who meets the qualifications listed in 22 VAC 40-71-60 B and performs the duties of an administrator. The standards do not mandate what title a facility gives the person performing these duties.

Question: If a nursing home and ALF are housed under the same roof, can they have the same administrator?

Answer: Yes, if the assisted living facility and nursing home are part of the same building.

March 1998

Standard 70.A.5

Question: Do people who come into an ALF to do staff training need to have a criminal record check?

Answer: No. Unless the trainer is hired as an employee of the facility, he does not have to have a criminal record check.

Standard 80.C

Question: Do part-time employees have to meet the 7-day, period in meeting the training requirement?

Answer: Yes.

Standard 80.E

Question: Can some of this required annual training for direct care staff be delivered by videotape with a facilitator instead of a live presenter for every inservice?

Answer: Yes. Some of the annual training can be delivered by a videotape with a facilitator as long as the facilitator has verifiable expertise on the topic and can provide guidance as needed. The facilitator or administrator should determine the number of training hours to be credited to staff for the training and certificates or some type of documentation should be provided to staff trained.

Standard 80.E

Question: What period of time should be looked at for annual training - calendar year, license year, employment year?

Answer: The employment year is to be used to comply with the annual training requirement. This means that the eight hours of training must be obtained within one year from the date the staff person began employment. In subsequent years, the eight hours of required annual training would always be based on the anniversary of the date the person started to work at the assisted living facility. For example if the staff person began to work on February I5, each year the staff person would need to obtain the required eight hours of training between February 15 of one year and February 14 of the next year.

Question: Is first aid/CPR included in the annual training required for staff or is this in addition to?

Answer: First Aid/CPR is in addition to the annual training required for staff by Standard 80.E.

Standard 110.A

Question: Does the staff member's record have to be kept at the facility or can personnel records be kept at a central or main office away from the facility site?

Answer: Personnel records that contain the information required by the ALF regulation must be kept at the ALF. Standard 180.D states that "all records which contain the information required by these standards for both residents and personnel shall be retained at the facility…." A provider may request an allowable variance if he believes this creates a hardship and a variance would not endanger the safety or well-being of persons in care.

Standard 110.C.2.c

Question: If a staff person had an x-ray, does it have to be repeated?

Answer: Only if required by a physician or a future change in policy by the Department of Health.

Question: If a person had a positive Mantoux and goes through all of the resulting tests and is found to be free of TB in a communicable form, does he have to be tested again?

Answer: No, unless the physician indicates otherwise.

Question: Do all current staff have to have a Mantoux starting now if tests on file are more than one year old?

Answer: Yes.

Question: Who has to be retested annually?

Answer: All staff who have not had a significant reaction previously.

Question: Are we saying that only 2 types of tests are acceptable, the Mantoux and the x-ray?

Answer: No. They physician may require another type of test.

Question: Define physician designee on the TB form?

Answer: Person approved by physician to sign form.

March 1998

Standard 110.C

Question: Do people who come into an ALF to do staff training need to have a TB test?

Answer: If the sole reason the people are coming into an ALF is to do staff training and the people do not come into direct contact with the residents, then they do not need to have a TB test.

Standard 110.C.1.b

Question: Does "licensed facilities" include facilities licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services?

Answer: Yes. "Licensed facilities" can refer to any type of facility licensed by a public agency in Virginia. However, in order for the previous statement of tuberculosis screening to transfer, the screening and documentation must conform to the requirements contained in the assisted living facility standards.

July 1998

Standard 110.C

Question: The Mantoux (PPD) testing TB screening - is this the one or two step test?

Answer: The Mantoux: (PPD) test for TB screening may be one step or two step, depending on history of person being tested. Mantoux tests should be administered as follows:

a. Initial screening for TB should be the two step test. This test is more accurate and establishes a baseline for annual testing.

b. If the employee can present documentation of two-step testing with negative results within three months, the new hire screen can be the one-step.

c. If the two-step screen is done upon hire, the one-step screen is then done annually.

Question: Regarding TB test - Tine or PPD?

Answer: The standard requires the use of the PPD (Mantoux) test, not the Tine test. The PPD Mantoux) test is recommended by the Centers for Disease Control and Prevention; the Tine test is no longer recommended.

Question: Do staff who were on hired prior to February 1, 1996 have to have an annual Mantoux test?

Answer: Yes, unless indicated otherwise by a physician for medical reasons. The initial Mantoux test should be two-step and thereafter, one-step.

Question: Can freedom of TB in a communicable form be determined other than by a Mantoux test?

Answer: A positive PPD does not necessarily indicate the presence of active disease. If a person has a positive PPD of 5mm or more, AND has had close contact with a known active case of TB OR is exhibiting symptoms of the disease, a chest x-ray and sputum culture would be done as deemed appropriate by a physician. If a person has a positive PPD of 5mm and none of the above has occurred, usually additional testing is not done.

July 1998

Standard 110.C.2.c

Question: Please clarify if annual tuberculin testing is a requirement of employment. The standard reads that if not previously positive, then annual testing is required but not an annual chest x-ray. However, if someone is a positive reactor, you would do a chest film, not another skin test.

Answer: All employees with negative results of a Mantoux skin test must be retested annually with the Mantoux test. If an employee has a positive reaction to the Mantoux test, annual chest x-rays are not required by the standard, but the Centers for Disease Control and Prevention recommends annual screening as deemed appropriate by the physician.

Question: If a person did not react significantly to a Mantoux TB skin test, do they have to be retested annually?

Answer: Yes.

October 1998

Standard 110.C.1b

Question: Does “licensed facility” include a licensed home health agency?

Answer: Yes.

April 1999

Standard 110.C.2.c

Question: If a new staff member has reacted positively to a Mantoux skin test and has a clear x-ray to show there is not TB, why shouldn't he be tested for TB annually? Couldn't that staff member contract TB just like the staff member that had a negative Mantoux skin test?

Answer: Annual chest x-rays are not required, however, the staff member could contract TB, and therefore should be screened annually. If the doctor has determined that chest x-ray is the appropriate method of screening due to a previous positive Mantoux, then the x-ray would be the annual screen.

Question: If someone has a positive skin test but is then shown not to have TB in a communicable form, can he subsequently develop an active case of TB?

Answer: Yes.

Standard 120.A

Question: If a person has an EMT card, is that acceptable for meeting this standard?

Answer: Persons currently certified as an emergency medical technician would meet this standard under "a similarly approved program." Special approval is not needed from your licensing office.

Question: If a person has received training in first aid through an EMT community out-reach program, is that training approved?

Answer: If the program is taught by an EMT instructor and covers the topics listed on the VDSS First Aid and CPR Curriculum Form (032-05-100 (1/02), the training would be approved. The approval should be requested on Form 032-05-100 (1/02) through your licensing office.

Question: Must an RN or LPN or staff with current first aid certification be on duty 24 hours a day?

Answer: Yes

Question: Does EMT/paramedic training cover this standard?

Answer: Persons currently certified as EMTs or paramedics, are covered for this standard.

Question: Can the First Responder course be taken to meet this requirement of this standard even though the certification is good for 4 years, rather than 3? That is, does the course meet the first aid requirement and can it be taken every 4 years?

Answer: The First Responder course meets this standard for the first three years as a similarly approved program. Special approval is not needed from your licensing office.

Question: Does the National Safety Council First Aid course meet this standard?

Answer: The National Safety Council First Aid course meets this standard (as long as the certification is current) as a similarly approved program. Special approval is not needed from your licensing office.

Standard 120.B

Question: Does the National Safety Council CPR course meet this standard?

Answer: The National Safety Council CPR course meets this standard (as long as the certification is current) as a similarly approved program. Special approval is not needed from your licensing office.

Question: Does the American Heart Association CPR course meet this standard?

Answer: The American Heart Association CPR course (basic or advanced life support, not the Heart Saver Course) meets this standard (as long as the certification is current) as a similarly approved program. Special approval is not needed from your licensing office.

July 1998

Standard 120.B

Question: Does the American Heart Association Heart Saver Plus course meet this standard?

Answer: The American Heart Association Heart Saver Plus course meets this standard (as long as the certification is current) as a similarly approved program. Special approval is not needed from your licensing office.

The Basic Heart Saver course does not meet this standard. The Basic Heart Saver course does not have testing (written knowledge test and demonstrated skills test) and the card/certificate states that the person has been a participant in the course and not that the person has successfully completed the course.

The Heart Saver Plus course does have testing and a successful completion card/certificate.

Question: Does the American Heart Association Health Care Provider course meet this standard?

Answer: The American Heart Association Health Care Provider course meets this standard (as long as the certification is cur-rent) as a similarly approved program. Special approval is not needed from your licensing office.

October 1998

Standard 120.A

Question: Does an American Red Cross Community First Aid and Safety Instructor meet instructor requirements?

Answer: Yes.

Standard 120 and Others

Question: In the standards when the words "on the premises" or "at the facility" are used, how does this apply to facilities with multiple buildings? For example, a facility has three buildings on a site, all under one license. Can there be one first aid kit for all three buildings and one staff person for all three building with first aid/CPR? Regarding Standard 3.7.G in *General Procedures and Information for Licensure,* where should the license and other documents be posted?

Answer: The words "on the premises" and "at the facility" include all the buildings which are under the same license. In the example of three buildings on a site that are all under one license, the standard only requires that there be one staff person with first aid/CPR for all three buildings. Of course, the licensee must protect the physical well-being of the residents, which is required by Standard 50. To meet Standard 50, it may be necessary to have more than one individual with first aid/CPR, even though this is not specified in Standard 120. Although Standard 120 requires one first aid kit, the standard also requires that the kit must be easily accessible. When there are three buildings on a site, it may be that the first aid kit in one building is not easily accessible to the other buildings. It may therefore be necessary to have a first aid kit in each of the buildings.

Regarding Standard 3.7.G in *General Procedures and Information for Licensure,* the license and other specified documents must be posted at each public entrance of each of the three buildings.

Standard 120.B

Question: Is the two year certification for CPR given by the American Heart Association acceptable to meet the standard?

Answer: The course must be one which has been approved by the Department and the person must be certified on an annual basis. A two year certification is only good for the first year as far as compliance with the standard.

Standard 130.C

Question: Does “buildings that house 19 or fewer residents” refer to actual census in a building or licensed capacity?

Answer: “Buildings that house 19 or fewer residents” refers to the actual census in a building, not the licensed capacity.

October 1998

Standards 130.A, 110, and 150.F.12

Question: Is it acceptable for a private duty nurse or a companion to take over the duties of assisted living facility staff on a continuing basis, i.e., not for a temporary illness? Some residents have private duty nurses or companions paid for by themselves or their families. In one case, at the family's request the licensee hired a companion that was part of the facility's staff when a resident's health declined to the extent that 24 hour care was needed. Shouldn't that resident be in a nursing home? If a private duty nurse or companion is providing care in place of facility staff, what is the facility's responsibility? Should there be something in the agreement about the arrangement? Does the facility need to have any records on file for a private duty nurse or companion hired by a resident or by a resident's family?

Answer: It is acceptable for a private duty nurse or companion to take over the duties of assisted living facility staff on a continuing basis when certain conditions are met. Because the facility is responsible for the physical, mental and psychosocial well-being of residents, the facility is responsible for the services and care provided by a private duty nurse or companion who is performing staff duties. Therefore, an assisted living facility must be involved in selection or approval of the private duty nurses or companions. It is also the responsibility of the facility to assure adequate training and supervision and to monitor appropriately. Any documentation regarding resident care would have to be maintained as required by the standards. Moreover, there would need to be a written agreement between the facility and the private duty nurse or companion which would specify his or her duties. There would also have to be a description of the arrangement for care in the written agreement between the resident and the licensee/administrator.

A private duty nurse or companion who is performing the duties of assisted living facility staff on a continuing basis is acting as a staff member. The specifications regarding employee records and health therefore are required for this individual. In addition, training and/or orientation requirements which are necessary to protect the resident and others must be met.

In the case noted above, if 24 hour care is needed but it is not *continuous licensed nursing care,* this would not be prohibited by the standards. An individual who requires *continuous licensed nursing care* cannot be admitted or retained in an assisted living facility.

December 2001

Standard 130

Question: Does the exception for facilities housing 19 or fewer residents apply to:

(1) facilities housing a mixed population of residents with serious cognitive impairments who cannot recognize danger and

(2) facilities with special care units?

Answer: The exception at 22 VAC 40-71-130 C for facilities housing 19 or fewer residents does not apply to a facility with a mixed population or a special care unit. This is consistent with technical assistance issued August, 1997 on 22 VAC 40-71-700 B 1 of the Standards and Regulations for Licensed Adult Care Residences which stated, "Both of the direct care staff members must be awake at all times. Should a facility believe that circumstances warrant allowing one of the staff members to be asleep at night, an allowable variance may be requested."

Standard 140

Question: How long do the written communication records required by this standard have to be retained?

Answer: The standard does not require a specific retention period for written communications. The intent of the standard is to ensure that staff on all shifts are made aware of significant events or problems that residents may have had on a previous shift. Records should be retained long enough to be useful to staff in assuring that needs and concerns of residents, either physical, mental or emotional, are not overlooked or neglected and to assure that, if appropriate, any pertinent information is transferred to an affected resident's permanent record.

Standard 150

Clarification: Questions have arisen about residents assessed as capable of independent living. There are two issues: where they may live and whether they can be publicly subsidized.

Individuals who are assessed as independent can be admitted into an assisted living facility (ALF). A person does not have to meet the residential level of care criteria to live in an ALF licensed for residential living care. In other words, the person does not have to be dependent in any of the activities or instrumental activities of daily living to be an ALF resident.

The ALF regulations define "independent living status." The definition of "residential living care" specifies that independent living facilities that voluntarily become licensed are included under the residential living care level of service.

Individuals who are assessed as independent are not eligible for payments under the Auxiliary Grants Program unless they were public pay residents prior to February 1, 1996. Persons who are independent do not need the services provided by an ALF and therefore cannot receive public monies for those services, except for those who became public pay residents under the previous regulations and thus have been grandfathered.

Standard 150.B

Question: Interviews with the residents for admission - is that the resident and the responsible party or the resident and/or responsible party? Many times the hospitals discharge before a direct interview can take place but usually the responsible party interview occurs.

Answer: The home cannot agree to take the resident until they've had an interview with the resident.

Question: Can interviews be done with a personal representative if the resident is out of town or out of state?

Answer: No. The resident must be interviewed.

Question: Can the physical exam for a resident be completed on the day of admission?

Answer: Yes.

Question: Does the UAI for private pay residents need to be completed in total prior to admission?

Answer: Yes.

Standard 150.B.2

Question: Are you required to use the DSS forms for (A) "Report of Resident Physical Examination" and (B) "Individualized Service Plan" or can you use something similar?

Answer: As long as all areas are addressed and all information required by standards is covered, other forms may be used.

Standard 150.C

Question: Is the "written assurance" the agreement between prospective residents and the family?

Answer: The "written assurance" is a written statement made by the assisted living facility administrator which is provided to the resident that the facility has the appropriate license to meet the care needs of the resident at the time of admission. If it so desires, the facility can choose to include the "written assurance" in the written agreement/acknowledgment of notification between the resident and the licensee or administrator as long as the requirements for the "written assurance" are met.

Question: Would inclusion of the written assurance required by this standard in the written agreement be acceptable?

Answer: Inclusion in written agreement would be acceptable.

Question: If it is in the contract does it have to be written on a separate sheet of paper that we are licensed to meet the residents' needs?

Answer: If it's in the contract and a copy of the contract is given to the case manager or family, it would not have to be separate.

Standard 150.F

Question: On the physical exam form, parts 10, 11, and 12 of 150.F are not addressed.

Answer: Correct. These items are not appropriate for the admissions physical, although they may be addressed at the time of admission.

Standard 150.F.3, G, H, I & J

Question: Can the licensed health care professional be an RN on the facility staff?

Answer: Yes.

Standard 150.F.5

Question: If a resident is already on psychotropic drugs without a diagnosis should we contact the doctor and get a diagnosis?

Answer: Yes. The doctor should be requested to provide a proper diagnosis and to determine whether the resident still requires psychotropic medication.

Question: What if the examining physician refuses to address this item on the physical examination form, because he has no knowledge or has not prescribed any psychotropic medications?

Answer: The physical examination form is a model form. If documentation is available that addresses this item someplace else, that is acceptable.

Standard 150.F.5 (continued)

Question: Does this diagnosis and treatment plan have to come from a psychiatrist?

Answer: No.

Question: Is a medical physician okay?

Answer: Yes.

Question: Does this include all psychotropic meds? Sleepers? Hypnotics?

Answer: Yes.

Standard 150.F.9

Question: What about insulin dependent diabetics who can't give their own insulin? 24 hour nursing?

Answer: Staff with Med. Management Training/Insulin Module can administer insulin. A very brittle diabetic may need 24 hour nursing.

Standard 150.K

Question: If a resident is receiving hospice care can they have IVs for comfort measures only?

Answer: This would depend on the requirements of the hospice program.

Standard 150.L

Clarification: If the same person is completing both the uniform assessment instrument (UAI) and the physical examination report, it is not necessary to repeat the same information on the physical examination report that is on the UAI. The person can make reference to the UAI (e.g., "see UAI") only for that information needed on the physical examination report which is the same as information provided on the UAI. All other parts of the physical examination report must be completed.

Question: Since individuals who were residents prior to February 1, 1996 are not required to have new physical examinations, how will licensing staff determine if they have any of the prohibited conditions?

Answer: All individuals who were residents prior to February 1, 1996 will have had UAIs completed on them by February 1, 1997. Assessors completing the UAI should not be approving anyone for ALF placement who has a prohibited condition. The private pay UAI asks the question of whether a resident has a prohibited condition. Each of the prohibited conditions is indicated on the full public pay UAI, although in some cases additional information may be necessary.

Question: Will all current residents be required to have new physicals?

Answer: No.

Standard 150.Q

Question: Can respite care stays qualify as emergency stays?

Answer: Respite care stays cannot qualify as emergency stays, unless the definition of emergency placement: is met. An emergency placement is defined in the ALF regulations as "...the temporary status of an individual in an assisted living facility when the person's health and safety would be jeopardized by not permitting entry into the facility until the requirements for admission have been met." The ALF regulations define respite care as "...services provided for maintenance and care of aged, infirm or disabled adults for temporary periods of time, regularly or intermittently." Respite care and emergency placements are two completely different concepts.

Standard 150.S.16.

Question: What is the definition of advance directives?

Answer: A witnessed written or oral statement voluntarily executed by an adult capable of making and communicating an informed decision prior to the time he is diagnosed as suffering from a terminal condition that life-prolonging treatments be withdrawn or withheld as outlined in the Health Care Decisions Act.

Standard 150.T

Question: Do all homes need to sign new agreements with residents or can homes attach an addendum to address new items required to be in the agreement, e.g., bed hold policy, and use the addendum as an update to the original agreement?

Answer: Homes can attach an addendum to address the new items and use the addendum as an update to the original agreement. The addendum must be dated and signed by the resident or the appropriate personal representative and by the licensee or administrator. The fact that an addendum exists must be noted in the original agreement. Copies of the addendum are to be provided to the resident and any personal representative and are to be retained in the resident's record with the original agreement.

Standard 150.X

Question: If a resident is temporarily detained but not committed and if that resident has been disruptive to others in the facility before being detained, without indication that the therapy has been effective, why would the facility have to ensure it would take the resident back? Would that not be a quality of life issue for the remaining residents?

Answer: The intent of the standard is that the person who is not committed has a place to return to and that he is not discharged from the facility without a good reason and without an orderly process. Should the person return to the facility and continue to be disruptive with no indication that therapy has been effective, and his condition presents an immediate and serious risk to the health, safety or welfare of himself or others, an emergency discharge may be in order.

Question: This standard refers to Code Sections 37.1-67.1 & 37.1-67.3. What are these sections, what do they reference?

Standard 150.X (continued)

Answer: These sections of the Code of Virginia are under Title 37.1, Institutions for the Mentally Ill; Mental Health Generally. They are part of Chapter 2, Admissions and Dispositions in General and more specifically, Article 1, Admissions. Section 37.1-67.1 is entitled "Involuntary temporary detention; issuance and execution of order." Section 37.1-67.3 is entitled "Same; involuntary admission and treatment." Anyone who would like a copy of these sections of the Code may contact the Division of Licensing Programs at 804-692-1776.

Question: Explain what temporarily detained (37.1-67.1) means.

Answer: Not admitted as a permanent resident to an inpatient facility. A temporary detention order is issued by a magistrate for emergency psychiatric evaluation or treatment prior to placement. The duration of the temporary detention may not exceed 48 hours prior to a hearing.

Standard 150.Y

Question: Can a resident be hospitalized and subsequently returned to the facility and not be considered a new admission (paperwork)?

Answer: Yes, if the resident is not discharged.

February 1997

Standard 150.F.11

Question: Unless an individual's independent physician determines otherwise, he cannot be admitted or retained by an assisted living facility (ALF) if he requires maximum physical assistance and meets Medicaid nursing facility level of care criteria. Is there a specific form for use by an individual's physician if the physician makes such a determination? Can the determination be a general statement that the individual's needs can be met or must it be specific to Standard 150.F.11?

Answer: There is not a specific form for use by an individual's physician to indicate a determination made regarding the above. The determination cannot be a general statement that the person's needs can be met but must be specific to Standard 150.F.11. An example would be "I (name of physician) have determined that even though (name of person) requires maximum physical assistance and meets Medicaid nursing facility level of care criteria, his needs can be met in an ALF and ALF care would be appropriate for him." The statement is to be signed by the physician and dated. A physician making such a statement should be aware of both the definition of maximum physical assistance and the Medicaid nursing facility level of care criteria. The physician should also be familiar with the type of care that is provided in an assisted living facility. Of course, each facility must then determine whether it can meet the needs of each individual.

Standard 150.Q & R

Standard 170 of the *Standards and Regulations for Licensed Assisted living facilities* and Standard 20 of the *Assessment in Adult Care Residences* require that, as a condition of admission, the ALF obtain a completed Uniform Assessment Instrument (UAI) prior to admission to the facility. In addition, section 10 of the *Assessment in Adult Care Residences* addresses emergency placement. An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. Prior to *placement,* the need for an emergency placement must be documented and approved by a Virginia Adult Protective Services (APS) worker or case manager for public pay individuals or by a Virginia APS worker or independent physician for private pay individuals. This is the ONLY instance in which an individual may be placed in an ALF without first having, been assessed to determine if he or she meets ALF level of care. In emergency placements, the UAI must be completed within seven working days from the date of placement by an appropriate assessor. If a case manager is the assessor for a public pay individual, then the assessment must be done by a case manager in the jurisdiction where the individual lived prior to the emergency placement.

If an ALF admits any individual as an emergency placement without prior approval and documentation by a Virginia APS worker or case manager for public pay individuals or by a Virginia APS worker or independent physician for private pay individuals, the facility is not in compliance with regulatory requirements and may be sanctioned. In the case of individuals receiving assisted living care services, the Department of Medical Assistance Services may not reimburse for the period of time that the individual was in the care of the facility without proper authorization (*Assisted Living Services Interim Instructions, July* 1996, Chapter IV, pages 10 and 21, and Chapter V, page 6).

August 1997

Standard 150.F.7

Question: We work with clients who are in the process of learning to do self G-tube care or who are just beginning to eat orally. Given that we provide intensive rehabilitation, will we be able to continue to treat these folks in our program? They usually do not have treatment alternatives to our program.

Answer: According to Standard 150.F.7, the resident must be capable of independently feeding himself and caring for the tube, except as follows. Standard 150.I specifies that if the resident so requests, care may be provided by a physician licensed in Virginia, a nurse licensed in Virginia or by a home care organization licensed in Virginia when the resident's physician determines that such care is appropriate. This allowance does not apply to auxiliary grant recipients.

Standard 150.K

Question: How would DNR orders work when a resident requests hospice care?

Answer: Hospice care is no different from any other care as regards DNR orders. When a resident requests hospice care, usually it is because of a terminal condition and he/she does not want to be resuscitated. However, a DNR order is still required and the physician writes this after consultation with the patient and/or responsible party.

Standard 150.L.8

Question: If a person transfers from a nursing home to an ALF, what are the requirements for TB testing?

Answer: The screening for tuberculosis, as part of the required physical examination, must occur within 30 days prior to the date of admission to the ALF.

Question: If a person transfers directly from one ALF to another ALF, what are the requirements for TB testing?

Answer: The screening for tuberculosis, as part of the required physical examination, must occur within 30 days prior to the date of admission to the ALF to which the person is going.

March 1998

Standard 150.B

Question: If a hospital History and Physical Examination (H & PE) has been completed, can a one page addendum be done by the physician?

Answer: A prospective resident must have the Uniform Assessment Instrument (UAI) completed by a person qualified to do so as specified in the ALF regulations. The UAI state form must be used; substitute forms are not allowed.

The Division of Licensing Programs' physical examination form, on the other hand, is a model form and as such, is not required to be used. As long as all the information required by the ALF regulations is included, an alternate form or other document may be utilized. If required information appears on the hospital H & PE form, it need not be repeated. However, information required by the ALF standards that is not included on the H & PE must be provided on the model physical examination form or on another form/document. An addendum to the H & PE done by the physician would be an appropriate way to include any additional required information.

Standard 150.F

Question: If a private pay resident is at the nursing home level, but can afford to pay a companion aide for 24 hour care, can the resident remain in assisted living?

Answer: It depends upon the specific situation. Individuals requiring continuous licensed nursing care, which is a condition prohibited by this standard, cannot remain in the assisted living facility. However, it is possible for an individual to meet the criteria for both a nursing home and an assisted living facility. In such a case, the person can remain in the assisted living facility as long as his needs can be met in that setting.

Standard 150.K

Question: If a private pay resident is in a hospice program, but can afford to pay a companion aide for 24 hour care, can the resident remain in assisted living?

Answer: Yes. The regulations allow any person (private pay or public pay) to reside in an assisted living facility and receive hospice care, as long as the resident has requested the care, the hospice program has determined that such program is appropriate for the resident, and the care is provided as specified in the Code of Virginia. Because hospice care may be provided notwithstanding the conditions prohibited by Standard 150.F, a person receiving hospice services in an ALF may have one or more of the prohibited conditions.

Standard 150.F

Question: Can a resident with an indwelling urinary catheter be admitted or retained in an ALF?

Answer: Yes. This condition is not prohibited in an assisted living facility. However, it is important to note that urinary catheters must be inserted under sterile conditions by a licensed health care professional. Care of the catheter is critical. There must be careful observation for signs and symptoms of disease, or other complications, by an individual trained to do so. Daily catheter care is also necessary and can be done by a trained Certified Nurses Assistant or trained direct care staff person. If these measures are not taken, life-threatening infections can result. Thus, these residents cannot be admitted or retained unless the facility is fully prepared to meet their specialized health care needs.

Question: There are questions about antibiotic resistant infections such as MRSA, GRE, VRE and whether they are "prohibited conditions" in ALFs. It is said they are not airborne infections.

Answer: Although these infections are not "prohibited conditions" in ALFs, they are extremely serious and require special handling by knowledgeable staff. The University of Virginia uses Contact Isolation for patients with Vancomycin resistant Enterococci (VRE) which means the staff must wear gowns and gloves when caring for these patients. For patients infected with Methicillin resistant Staphylococcus aureus (MRSA) in the lungs they use Contact and Droplet Isolation, which includes gowns, gloves and masks, which is recommended by the Centers for Disease Control and Prevention.

The Virginia Department of Health Office of Epidemiology gave the following information:

> These infections are not prohibited --- the key is hand washing and using the appropriate barriers (gloves, gowns, masks). Don't put them in a room with someone who is severely immunosuppressed or with someone who has an open wound. If there are others with the same infection then putting them in the same room is an option for room assignment.

Although not a prohibited condition, an individual with an antibiotic resistant infection cannot be admitted or retained in an ALF unless his specialized health care needs can be met in the facility.

Standard 150.F.2

Question: What about residents who have ongoing III/IV dermal ulcers? Wouldn't they be ineligible for an assisted living facility?

Answer: Stage IV dermal ulcers are prohibited in assisted living facilities. A stage III dermal ulcer is prohibited unless it has been determined by an independent physician to be healing AND periodic observation and any necessary dressing changes are performed by a licensed health care professional under a physician's treatment plan.

Standard 150.F.2

Question: What would you consider a reasonable time for decubiti/vascular sores to heal?

Answer: This is almost impossible to answer because of the many variables such as age, nutrition, presence of disease (such as diabetes), and quality of nursing/medical care. The quality of nursing/medical care as it relates to relieving pressure, and nutrition, is critical - the better the quicker. Vascular sores, especially in diabetics, can become gangrenous and result in amputation, a common occurrence in the absence of appropriate care.

Note: The term "decubiti" is generally considered outdated. Current medical literature refers to such wounds as "pressure ulcers."

Standard 150.F.3, H, and I

Question: Regarding intravenous therapy, does a nurse have to be in the building around the clock?

Answer: Continuous intravenous therapy must be administered directly by a licensed physician or a licensed nurse, including a nurse from a licensed home care organization, under a physician's treatment plan. The licensed physician or nurse must be in the assisted living facility around the clock.

Intermittent intravenous therapy must be provided by a licensed health care professional, acting within the scope of his/her profession. The licensed health care professional must initiate the infusion, remain in the assisted living facility until it is infused, then discontinue the infusion.

Note: See exception in Standard 150.I for recipients of auxiliary grants.

Standard 150.F.7 and I

Question: A facility has a gastric tube for a brain-injured resident. The facility does not have 24 hour 7 day per week licensed nurse coverage. Can trained staff care for the tube under the supervision of a nurse who is not always on duty when care would be needed? Is a home care organization under Standard 150.I restricted to a licensed nurse?

Answer: Unless the individual is capable of independently feeding himself and caring for the tube, care must be provided by a licensed physician or by a licensed nurse, including a nurse from a licensed home care organization, under a physician's treatment plan. It is not acceptable for a staff person who is not a licensed physician or nurse to provide the care.

Note: See exception in Standard 150.I for recipients of auxiliary grants.

July 1998

Standard 150.L.8

Question: The Mantoux testing for TB screening - is this the one or two step test?

Answer: The Mantoux (PPD) test for TB screening may be one step or two step, depending upon the (prospective) resident's medical history. The two-step screening is recommended by the Centers for Disease Control and Prevention. If at a later date the resident is exposed to TB, a record of two-step testing provides an accurate base line for determining recent or previous infection with TB. Thus the individual can be treated accordingly.

October 1998

Standards 150.I and K

Question: If a resident is in a hospice program as per Standard 150.K, must the care for a gastric tube, when the resident is not capable of independently feeding himself and caring for the tube, be provided by a licensed physician or a licensed nurse as per Standard 150.I?

Answer: Yes. The care for a gastric tube must be provided as specified in Standard 150.I, even if a resident is in a hospice program. Standard 630.K may also apply.

Standard 150.K

Question: Can a person who is receiving hospice care in an assisted living facility have one of the prohibited conditions?

Answer: Because hospice care may be provided notwithstanding the conditions prohibited by Standard 150.F, a person receiving hospice services in an assisted living facility may have one or more of the prohibited conditions.

Standard 150.L

Question: Can a nurse practitioner perform the physical examination? In Standard 10, under the definition of licensed health care professional there is a note which specifies that responsibilities of physicians may be implemented by a nurse practitioner within the parameters of professional licensing.

Answer: A nurse practitioner can perform the physical examination within the parameters of professional licensing. It is within the scope of his/her profession. The nurse practitioner must be chosen by the resident, not by the facility, and must have no financial interest in the assisted living facility, directly or indirectly, as an owner, officer, or employee, or as an independent contractor with the residence.

April 1999

Standard 150.F.9

Question: Would a permanent indwelling catheter (Foley) be a condition that would be required to have "continuous nursing care 24 hours a day?" Also, would a resident who required in and out catheterization two or three times per day, and who may or may not always do this himself, come under "continuous nursing care?"

Answer: A permanent indwelling catheter (Foley) would not require continuous nursing care 24 hours a day. It must be inserted by a licensed health care professional using sterile technique and if there is no evidence that would indicate the need for earlier intervention, it must be changed monthly by the licensed health care professional. However, these catheters require special daily care and close observation by trained staff as complications can be life-threatening.

If a resident requires "in and out" catheterization two or three times per day and is unable to perform this task independently, it must be done by a licensed health care professional. When in and out is done, a straight catheter is used (not a Foley), but the procedure must be done using sterile technique to prevent infection. This would not require continuous nursing care.

Question: What about residents who require nebulizers or continuous oxygen but can't do or handle these on their own? Can staff do it for them? Is 24 hour nursing required?

Answer: Twenty-four hour nursing is not required for residents who require nebulizer treatments or continuous oxygen but these must be administered and supervised by staff who have been properly trained. If medications are used with the nebulizer treatment, these must be administered by a medication aide who has successfully completed a medication training program approved by the Board of Nursing or by a staff person licensed by the Commonwealth of Virginia to administer medications.

Standard 160.J

Question: Return of property or things held in the facility to be returned within 60 days - some residents have moved to places hours away. Will the facility be responsible to pay the freight charges to send the items?

Answer: The facility is not responsible for paying the freight charges to send the items. However, the facility is to assist the resident and his personal representative, if any, in making appropriate plans to have property or things of value held by the facility returned to the resident. Please note Standard 160.D which speaks to assisting the resident in the discharge process and notes that "primary responsibility for transporting the resident and his possessions rests with the resident or his personal representative."

Question: Will the 60 days be exempt for returning personal belongings if there is a pending court case in dispute about the refund?

Answer: The home would need to comply with the time frame. If he court rules in favor of the home then it will get the money back through other means.

Question: Can you hold resident belongings until payment of the bill is received?

Answer: No.

Standard 170

Question: On the private Pay UAI under psychosocial status, abusive/aggressive/disruptive less than weekly is D=Dependent. However, under the Nursing Home Pre-Admission Screening Manual (3-19-94), page 4, under 8) Behavior Pattern & Orientation of "Abusive/Aggressive/Disruptive < weekly + Oriented or Disoriented" is rated "d" meaning semi-dependent. Which standard will apply?

Answer: For ALFs, abusive/aggressive/disruptive less than weekly is D=Dependent.

Question: Why the difference in UAI forms between public and private pay clients?

Answer: Since July 1994, through the direction of General Assembly resolution, all publicly funded human service agencies in Virginia have been using the UAI as the one common assessment form to gather information to determine an individual's care needs, to determine service eligibility, and to plan and monitor client care needs across agencies and services. Local departments of social services use the UAI to assess the need for any long-term care service. State law requires UAI assessments for all ALF residents, regardless of payment source, upon admission and periodically thereafter. Because the information needed for private pay residents in ALFs is significantly less than the amount and the scope of the information needed for public pay residents, the private pay version of the form is shorter. The private pay version is used only in ALFs; it is not used to determine the need for a broad range of public services. Neither is it used to determine service eligibility. Social and financial information which is not relevant because of the resident's payment status is not included on the private pay version of the form.

Question: If family info is wrong on UAI do we have to re-do after admission?

Answer: If you know that information on file is incorrect and you have correct information would be added to file and the person who had completed the UAI would be so notified.

Standard 170.A

Question: Once facility staff have received training in completing the private pay UAI, can the facility charge the private pay residents for completion of the UAI?

Answer: Yes. This is not addressed by regulation.

Question: Do we need to go back and complete the UAI for residents who are private pay and were in our facility prior to February 1, 1996?

Answer: Yes, the UAI must be completed for these residents before February 1, 1997. Since Standard 170.E specifies that UAIs must be completed at least once every 12 months, you have one year from the effective date of the standards to have this done.

Question: Would a licensed rehabilitation provider be able to conduct the UAI assessment?

Answer: A licensed rehabilitation provider would not be able to conduct the UAI assessment unless he was one of the entities specified in the standard as being able to complete the UAI.

Standard 170.A (continued)

Question: I manage an ALF operated by CSB. Can I, my staff or case managers of the CSB complete the UAI of my residents? Clarification of the question: Assuming that CSB has contract with DMAS to complete UAI for current and prospective ALF (AG) residents, would it be a conflict of interest for CSB to complete initial UAI on residents of the ALF operated by the CSB?

Answer: ALF direct care staff who are also CSB employees cannot perform assessments on AG residents. However, qualified staff of CSBs could perform this function if they are not direct service staff in the ALF. In circumstances where a CSB employee is placed in a facility to facilitate case management activities, this staff person can complete the assessment.

Question: If a CSB operates an ALF, can the CSB case managers complete the UAIs on the residents in the facility?

Answer: Yes, if they are qualified.

Question: If the facility has a level of care form in place that includes all the items on the state form, will our forms satisfy the UAI?

Answer: No.

Question: What about private pay residents who are due to spend-down within six months? Should they be classified at the time of application on the UAI differently?

Answer: These residents would be private pay initially and then would need to have the public pay UAI completed in order to receive the auxiliary grant.

Question: How would a person arrange to perform contract services as a qualified assessor for other residents outside of their current facility?

Answer: A qualified assessor would need to have a contract with DMAS.

Standards 170.A.1

Question: What do we do with private pay residents who moved in on or after February 1, but before we received UAI forms?

Answer: Complete a UAI as soon as possible, but by no later than February 1, 1997.

Question: The qualified assessor after the April training - will this be the status of the participants of the training?

Answer: No. Those attending will be facility employees with documented training.

Standard 170.A.1.b

Question: Can licensing staff do UAI training for private pay?

Answer: If licensing staff have been trained in completing the UAI they could do UAI training for private pay as part of their regular work. Their caseloads and other responsibilities, however, prohibit them from doing this training. They could not do this training outside of their regular work as this would be a conflict of interest (especially if payment is involved) Other staff in the Department of Social Services have been conducting this training for facilities in group sessions. A brochure has been sent out advertising several sessions over the next few months.

Question: Can a facility employee with documented UAI training contract with several facilities to complete the UAI for their private pay residents or can the employee only complete the UAI for the residents of the facility of which he is a regular employee?

Answer: A facility employee with documented UAI training can contract with several facilities to complete the UAI for their private pay residents. The employee is not limited to his place of primary employment. However, the employee must be hired, either directly or through a contract, by any assisted living facility that wishes to have him complete the private pay UAI for its residents, i.e., the person must be an employee of that facility for that purpose. Please note that a person may be considered a volunteer employee if there is no payment involved, but in such cases there must be a contract between the facility and the volunteer employee.

Question: For private pay residents, the uniform assessment instrument (UAI) may be completed by a facility employee with documented training in the completion of the UAI and appropriate application of level of care criteria, provided the necessary approval and signature are obtained. How can it be determined that the training has been "documented"?

Answer: Facility staff training in the UAI may be "documented" in one of the following two ways:

1) A certificate from UAI training offered by a state agency, such as the Department of Social Services or the Department of Medical Assistance Services; or

2) In writing, a description of the content of the training, the name of the trainer and his or her qualifications to provide UAI training, the organization/agency/facility from which the trainer came, the date of the training, and the length of the training.

   The documentation of the UAI training must be maintained in the employee's record.

Question: The UAI training which was provided in 1994 under the direction of the Virginia Long-Term Care Council was a combined effort of the Departments of Medical Assistance Services; Aging; Social Services; Mental Health, Mental Retardation and Substance Abuse Services, Rehabilitative Services; and Health. Does this training meet the requirement of Standard 170.A.1.b and if so, what would be acceptable documentation of attendance?

Answer: The UAI training under question does meet the training requirement of Standard 170.A.l.b. Attendance may be documented in either of the two ways noted in the response immediately above.

Standard 170.A.1.b (continued)

Question: Who else would be eligible to train, i.e., can facility employees who receive training from a state agency come back and train other employees and then does the 2nd round of employees qualify as assessors for private pay? How far down the line would this training be good for?

Answer: Yes, facility employees who received training from a state agency can train other employees and these "2nd round" employees do qualify as assessors for private pay. There are no limits as to how far down the line this could go. The Division has developed criteria for training which should be used as a guide to ensure that the training is appropriate. We would hope that the state would offer training in the private pay UAI periodically or that train the trainer sessions or material might become available, but there are no guarantees this will happen.

Standard 170.A.4

Question: Suppose the provider is not a qualified assessor or a person who has received training in completing the UAI?

Answer: The provider would have to get someone who is qualified to update the UAI.

Standard 170.C

Question: Individualized service plan - can the facility utilize its care service plan if it contains everything contained in the model form?

Answer: Yes.

Question: Do we need to go back to residents who were admitted before February 1 and do an individualized service plan?

Answer: Wait until the UAI is completed and then do an individualized service plan based upon the UAI and any additional assessments necessary to meet the care needs of the resident.

Question: Does the individualized service plan and UAI replace the basic needs assessment and service plan?

Answer: Yes, although additional assessments beyond what is included on the UAI may be necessary to meet the care needs of the resident.

Question: Does the service plan have to be in the resident's file or just on premises?

Answer: Must be in file, but a copy can also be in other facility locations for convenience of staff who may need to refer to service plan.

Standard 170.E

Issue: For private pay residents, reassessment should only occur when there is a change in a resident's condition, not at prescribed intervals.

Standard 170.E (continued)

Resolution: The actual issue was private pay residents who have independent living status, i.e., the resident is assessed on the initial UAI as capable of performing all activities of daily living and instrumental activities of daily living for himself without requiring the assistance of a staff member in the ALF. An allowable variance to the requirement that UAIs be completed at least once every 12 months will be considered for private pay residents with independent living status. The facility making the request needs to explain its plan to assure identification of a change in a resident's condition when the person can no longer maintain independent living status. At that point, another UAI would have to be completed.

Question: Re-do level of care change (UAI) every time there is a change in condition?

Answer: UAIs are to be done whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care. Other types of assessment may be needed if there are changes in the resident's condition that could affect the service plan.

Question: Can you explain how residents that are private pay and have been in your facility prior to February 1 are supposed to be handled? Do we need to go back and complete UAI or not?

Answer: The UAI must be completed by February 1, 1997.

Question: Regarding the initial assessments for public pay residents who were in the facility prior to February 1, will facilities have to select the UAI completion with the agencies or will they notify of the screening date?

Answer: The local agencies will coordinate with the other agencies and will notify the facility for assessments.

Question: Does a UAI have to be done for each person or only on the ones that have come in after February 1, and will you need a UAI on those residents that have been in the facility before February 1?

Answer: UAI will be needed on all residents.

Standard 170.H

Question: If our facility already has a Resident Service Plan do we have to do the State's service plan as well?

Answer: If the facility's service plan includes all required information, it would be enough on its own.

February 1997

Standard 170

Question: How do ALF and licensing staff determine the level of care from the Uniform Assessment Instrument (UAI)?

Answer: For public pay residents, the assessor completes the UAI and the Long-Term Care Preadmission Screening Authorization (DMAS-96) and applies the level of care criteria to determine level of care. The DMAS-96 specifies the level of care needed by the resident based upon the assessment. The assessor sends the completed UAI and DMAS-96 to the ALF. It is, of course, possible for ALF and licensing staff to determine the level of care needed by applying the levels of care criteria to the completed UAI. ALF and licensing staff must be familiar with the level of care criteria in order to recognize correct application of the criteria. By regulation, ALF staff must know when a resident no longer meets the level of care for which the ALF is licensed. For twelve-month reassessments when there is no change in the level of care, the assessor sends a copy of the completed UAI and the Adult Care Residence Eligibility Communication Document to the ALF.

For private pay residents, the private pay version of the UAI specifies the level of care for which the resident has been assessed. The determination of the correct level of care is made by the ALF staff completing the UAI or by whoever completes the UAI as allowed by the regulations. Applying the level of care criteria for ALFs, the person completing the UAI must determine whether the individual meets residential living, regular assisted living, or intensive assisted living and indicate the appropriate level of care on the UAI. The level of care determination process is explained in the *Users Manual: Virginia Uniform Assessment Instrument for Private Pay Residents of Adult Care Residences.*

Standard 170.A

Question: Regarding "supervision" on activities of daily living (ADLs), does giving reminders to a resident constitute dependency ("big D") or does supervision have to be intensive, i.e., just short of hands-on to create the "big D" dependency?

Answer: Giving reminders to a resident constitutes dependency ("Big D") provided that the reminder is needed to safely complete the activity. The *User's Manual: Virginia Uniform Assessment Instrument (UAI),* March 1994, page 14, states that dependence includes a continuum of assistance which ranges from minimal to total. Dependence means an individual needs at least the assistance of another person (human help only) OR needs at least the assistance of another person and equipment or a device (mechanical and human help) to safely complete the activity. Human assistance includes supervision (verbal cues, prompting) or physical assistance (set-up, hands-on care). A need for human help exists when the client is unable to complete an activity due to cognitive impairment, functional disability, physical health problems, or safety. An unsafe situation exists when there currently is a negative consequence from not having help.

Question: Does the UAI supervision definition mean that mental health/mental retardation (MHMR) diagnosis should automatically place a resident at assisted living care level?

Standard 170.A (continued)

Answer: No. The definition does not automatically place the resident at any level. On page 15 of the *User's Manual: Virginia Uniform Assessment Instrument (UAI),* March 1994, supervision is defined to mean that the client is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him to safely perform the complete activity. The definition of supervision *often* pertains to people with cognitive impairment, but not always, and may include those who need supervision for other reasons.

Question: Does a history of aggressive behavior require a resident to be placed at the assisted living care level?

Answer: No. A history of aggressive behavior does not automatically place the resident at any level. Each assessment of a resident must consider the resident's behavior at the point in time in which he or she is assessed.

Question: If staff have received training two years ago to do the full UAI, are they "grandfathered" to do the full UAI or only the short form for private pay residents?

Answer: ALF staff who have documented training in the completion of the full UAI and appropriate application of level of care criteria may complete private pay UAIs. They may not, however, complete the full UAI for public pay residents as regulation requires that only qualified assessors (i.e., those having a contract with DMAS to complete assessments) complete assessments for public pay individuals.

Standard 170.A.1

Question: For private pay, if hospital staff complete the 12-paged public pay UAI, can we accept that or do we need to complete another UAI at the facility? Do they cross over?

Answer: Yes, the ALF may accept a completed 12-page public pay UAI in lieu of completing the private pay UAI provided that the UAI accurately reflects the condition of the individual at the time of admission to the ALF.

Question: Can a licensed nurse (either RN or LPN) be able to do private pay UAIs?

Answer: Any individual, including licensed nurses, with documented training on the completion of the UAI and appropriate application of level of care criteria can complete the private pay UAI. This individual must, however, be an employee of the ALF, either directly or through a contract.

Standard 170.A.1.b

Question: Can a person who is not employed by any facility but who wants to contract with several facilities to do their UAIs for private pay do so? If he enters into a contract with a facility, can he do the UAIs? Can he do this for a number of facilities if he has contracts with them?

Standard 170.A.1.b (continued)

Answer: This standard and regulation 22 VAC 40-745-20, "Assessment in Adult Care Residences," allow for qualified staff of the ALF to complete the UAI for private pay individuals. Qualified staff of the ALF is an employee with documented training in the completion of the UAI and appropriate application of level of care criteria. A facility employee with such documented training can contract with several facilities to complete the UAI for prime pay residents. The individual must be employed by the facility for which he or she completes private pay UAIs, either directly or through a contract (i.e., the individual must be an employee of the facility for that purpose).

Question: Can the administrator make the person who completes the UAI the designee to sign?

Answer: A facility employee cannot be the administrator's designated representative who approves and signs a UAI for a UAI which the employee himself completed. However, the employee may be the administrator's designated representative for UAIs completed by other facility employees.

Standard 170.A.2

Question: Can an individual become a qualified assessor to do AG UAIs? The standard says a case manager or other qualified assessor and definition says an entity.

Answer: A qualified assessor, according to ALF Standard 10 and 22 VAC 40-745-10, "Assessment in Adult Care Residences," is an entity contracting with DMAS to perform nursing facility preadmission screenings or to complete the UAI for a home- and community-based waiver program, including an independent physician contracting with DMAS to complete the UAI for residents of ALFs or any hospital which has contracted with DMAS to perform nursing facility preadmission screenings.

Standard 170.C

Question: Individualized service plans are done within 45 days, then updated. How often - yearly?

Answer: As required by Standard 170.H, individualized service plans must be reviewed and updated at least once every 12 months. The plans must be reevaluated as needed as the condition of a resident changes.

Question: Who should sign the individualized service plan (ISP) according to the ALF standards? Standard 170.C does not say who should sign it. Does the standard intend for everyone participating in the development of the plan to sign it or is this just for DMAS?

Answer: The ALF standards do not require those who are involved in the development of the ISP to sign it. However, the facility would have, to maintain evidence or documentation of who was involved in the development of the plan. Having these people sign the ISP would seem to be an easy way of maintaining a record of who was involved in the plan's development. DMAS does require the signatures on ISPs for public pay residents who have been assessed for assisted living care.

Standard 170.C (continued)

Question: Can we stop doing the ISP after we have the UAIs and plan of care in place?

Answer: No. For the purposes of Medicaid-funded targeted case management for Auxiliary Grant applicants and recipients, plan of care does not mean the same as individualized service plan. When Medicaid-funded targeted case management services are provided, the case manager must use the Department of Medical Assistance Services guidelines for preparing and implementing the plan of care. The plan of care is completed by the case manager and addresses needs that cannot be met by the ALF. The ISP is completed by ALF staff and focuses on resident's needs addressed by VDSS licensing regulations. While different, the two complement each other.

Standard 170.H requires that ISPs be reviewed and updated at least once every 12 months. The standard also requires that the ISP be reevaluated as needed as the condition of the resident changes.

Standard 170.A.1.b

Question: Can the administrator designate more than one representative to approve and sign completed UAIs?

Answer: Yes.

Standard 170.A.4

Question: If an assisted living resident has been hospitalized, received skilled care and returned to assisted living, is a new H & P necessary, a new UAI, a new PPD? Our facility has licensed SNF and assisted living. Can we use the forms from SNF for assisted living? Presently we insist on everything being current per regulations even though the resident has been under the same roof (at times for more than 30 days).

Answer: If the resident was discharged from the ALF, then the procedure for readmission is the same as a regular admission. If the resident was not discharged, information must be updated as necessary and appropriate.

Any form required by the Department of Social Services must be used for assisted living. If they are not required forms, but are model forms, then the facility may use forms of its choice as long as all the required information is included.

Standard 170.C

Question: Can the person completing the individualized service plan (ISP) and the health care oversight person be one and the same?

Answer: Yes, the person completing the ISP and the health care oversight person may be one and the same. However, if practicable, it would be better to have one person completing the ISP and a different person providing the health care oversight.

Question: Since licensing does not require the signatures of those involved in the development of the individualized service plan (ISP), what happens if the signatures are left blank?

Answer: As far as licensing is concerned, if the signatures are not on the ISP, the ALF would have to maintain evidence or documentation in another place in the facility of those who were involved in the development of the plan. DMAS requires the signatures on ISPs for public pay residents who have been assessed for assisted living care and will take appropriate action as needed if the signatures are missing.

August 1997

Standard 170.C

Question: This is obviously looking for a team approach. What if individualized service plans (ISPs) are completed only by a facility staff member and how would the licensing inspector determine this?

Answer: An ISP is to be completed only by a facility staff member when there are no appropriate others who can be involved. Is the resident so confused or mentally incapable that he can not participate in making any decisions regarding his own care? Does a resident have no family members who are interested in participating in the ISP? Is there no one who has previously provided professional services to the resident who would appropriately be involved? And the list could go on.

The ALF must maintain evidence or documentation of who was involved in the development of the ISP. Having these people sign the ISP would seem to be an easy way of maintaining a record of who was involved in the plan's development, although ALF standards do not require signatures. DMAS does require the signatures for public pay residents who have been assessed for assisted living care.

Standard 170.C.1

Question: In identifying the needs on the individualized service plan, do the IADLs have to be included?

Answer: Yes. Whenever an instrumental activity of daily living (IADL) is identified as a need of an individual, it must be included on the person's individualized service plan (ISP). This is required by both this standard and Standard 170.D, which states that "the individualized service plan shall reflect the resident's assessed needs...." If a resident's need in respect to a particular IADL does not exceed a service that is routinely provided by the facility, then after a description of the need on the ISP, it is acceptable to make reference to another document (or documents) that explains the service and includes the other information required by Standard 170.C. The relevant parts of these other documents must be available to all direct care staff to assist them in understanding the overall service needs of the residents.

An example would be if a facility provides housekeeping services to all residents twice a week and this service is adequate to meet a particular resident's housekeeping needs, then after the need for housekeeping is noted on the resident's ISP, a reference may be made to documents such as the resident agreement and/or the facility's housekeeping schedule as long as these documents include the required information. In such a case , it would not be necessary to include specific information regarding the delivery of the housekeeping service on the ISP itself. However, if the resident has an allergy to certain cleaning products and as a result special cleaning supplies have to be used, this need and the specific way it is to be met must be detailed on the ISP.

Please note that the above answer applies only to IADLs under the described circumstances.

August 1997

Standard 170.C.4

Question: Regarding the individualized service plan, under expected outcomes/goals, is the term "to maintain status" ok?

Answer: No. Under some circumstances it may be apparent that aggressive services are being provided with the goal of preventing or slowing further deterioration. To establish a goal of "maintaining the status quo," however, runs the risk of allowing or expecting such deterioration, which will likely occur without a plan to combat it.

Standards 170.C and 170.D

Question: Can there be portions of an individualized service plan (ISP) that are preprinted so that the staff completing the plan circles/checks the most appropriate choice(s)?

Example: Bathing: Services to be provided

- Total assistance
- Partial assistance
- Prompting
- Monitoring water temperature
- Other _____

Answer: Yes, portions can be preprinted so that staff can mark the appropriate choice(s) as long as it is clear that this is the method being used and the choices are specific enough. In the above example, for instance, "partial assistance" does not adequately describe the service to be provided. Staff would have to describe the type and extent of assistance required by the individual. The other choices seem sufficient.

Standard 170.D

Question: The individualized service plan (ISP) is to reflect the resident's assessed needs and support the principles of individuality, personal dignity, freedom of choice and home-like environment and is to include other formal and informal supports that may participate in the delivery of services. What is licensing looking for here?

Answer: Some thoughts. There are many kinds of needs, e.g., physical, mental, emotional, psychological social recreational, etc. The ISP is to be tailor made for each resident, it should allow for and work towards a resident's greatest degree of independence possible, services should not be provided in. a way that decreases personal dignity, residents should participate in making decisions about their care to the extent feasible, and services should be provided in a home-like environment as much as practicable. Examples of formal supports may include home health agency staff and CSBs; examples of informal supports may include relatives and friends.

August 1997

Standard 170.I

Question: The last sentence of this standard requires that the staff person designated to review, monitor, etc., an individualized service plan must keep a resident's case manager, if applicable, informed of significant changes in the resident's condition. How is compliance with this last sentence determined?

Answer: The case manager completes a new or updated UAI whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care. Thus, in these cases, the case manager would be informed of significant changes in the resident's condition. The last sentence in Standard 170.I also applies when a resident is receiving targeted case management services or its equivalent. Since under these circumstances the case manager is coordinating certain services, it is important that ALF staff make him or her aware, in a timely fashion, of significant changes in the resident's condition. Documentation or evidence that the case manager was so informed should be maintained by the ALF.

March 1998

Standard 170.A

Question: Does a “big D” on orientation place a resident in the population of residents with serious cognitive deficits?

Answer: A dependency (“big D”) in orientation is never used alone as a criterion for assisted living facility placement but rather is used only as a combination variable with behavior. A “big D” for orientation/behavior occurs only when a person is disoriented to all three spheres (person, place and time) either some or all of the time and is abusive/aggressive/disruptive weekly or more. By regulation, this constitutes dependency in the combination variable “behavior pattern and orientation.” The care of such a person would need to be reflected in his or her individualized service plan and would be specific to that person’s identified needs.

April 1999

Standard 170.A and C

Question: Must a Uniform Assessment instrument (UAI) and an individualized service plan be completed for a respite care resident?

Answer: Yes. A respite care resident must have both a UAI and an individualized service plan. The UAI must be completed prior to admission and the service plan must be completed within 45 calendar days after admission.

Standard 170.C.4

Issue: The ISP model form (032-05-020) requires time frames for expected goals/outcomes, the standard does not. Some inspectors cite facilities if the time frames are not on the ISP, some do not.

Answer: For therapeutic services, a time frame is required since time frames are inherent in expected outcomes/goals. For on-going custodial services, such as assistance with dressing due to permanent paralysis, notation of a specific time frame is not necessary.

Custodial services are those intended to supervise, protect, and assist an individual. This is without an expectation and plan for the individual to attain a higher level of independent functioning.

Therapeutic services are those intended to help an individual obtain or maintain an optimal level of functioning, or to reduce undesirable changes to the physical, mental, behavioral, or social functioning. Those services are planned and goal-directed clinical interventions that may require documentation of a rehabilitative services professional as well as documentation by facility staff (see 22 VAC 40-71-650).

Standard 170.E

Issue: In answer to the question, "Re-do UAI every time there is a change in condition?", TA previously issued stated, "UAIs to be done whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care. Other types of assessment may be needed if there are changes in the resident's condition that could affect the service plan."

The UAI User's Manual (April 1998) states the reassessment should be done "whenever there is a permanent, significant change in the resident's condition. A permanent change is one which is expected to last 30 days or more."

The standard states the reassessments "shall be completed as needed as the condition of the resident changes AND whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care."

Some assessors were refusing to do reassessments when there was a change in the resident's condition. This perhaps was due to lack of consistency in guidance they were given in the April 1998 UAI User's Manual (pg. 9), in the Assessments in ACRs: Manual for Assessors (Chapter II, pg. 18), and in the April 2001 User's Manual for Private Pay Residents of ALFs (pg 6).

Answer: The reassessment is to be completed at least once every 12 months and whenever there is a change in the resident's condition that is expected to last more than 30 days OR appears to warrant a change in the resident's approved level of care.

Standard 180

Question: Do we have to keep financial records on the resident's medical chart or can we store them separately?

Answer: Records can be kept in different locations within the facility as long as they are easily accessible so as not to interrupt services to residents, separate for each resident, and available to licensing staff.

Standard 180.F

Question: Do family members and those with power of attorney have access to a resident's records?

Answer: The intent of this standard is to assure that a resident can see his own record if he wishes to do so. If another person has been legally appointed as conservator or guardian authorized to view the resident's record or if the resident has named a personal representative, that person may have access to the record.

Standard 210.D

Question: Does linen service provision mean that an additional charge can be made for those residents who request it or do all residents have to be given linen?

Answer: The home has the responsibility to assure that residents are provided with clean linen and that it is kept in good repair. If residents choose to bring their own linen they may, but if they need additional linen the home would have to supply that. Exclusive of public pay residents, the facility sets its fees.

March 1998

Standard 210.A & B

Question: A facility making application for ALF licensure plans to require residents to bring their furniture or rent it from the facility. The facility will serve private pay residents only. Is there anything that prohibits the facility from renting the furniture?

Answer: The facility is not prohibited from renting the furniture to private pay residents. The facility is responsible, however, for making sure that bedrooms contain the items required by the standards (and for encouraging residents to furnish or decorate their rooms as they would like). In all cases a resident's room must meet all applicable standards related to the type and condition of furnishings. The facility must make it clear in the written agreement that residents must bring their furniture or rent it from the facility and it must be clear what they have chosen to do. In addition, any specific conditions of the arrangement, including charges involved, must be specified in the written agreement. (See Standard 150.T regarding the written agreement.)

Whether the furniture is provided, rented, or brought by the resident, it must meet the regulations, including being kept clean and in good repair.

Please note that a furnished room is included as a mandated covered service under the Auxiliary Grants Program. Therefore, a facility cannot rent furniture to public pay residents, but must provide to them the items required for bedrooms by the ALF standards under its established Auxiliary Grant rate.

Standard 240.A

Question: Residents in residential living care are responsible for their own clothing - if someone becomes unable to maintain clean clothing, can an additional charge be made to those whose clothing is being cleaned by the staff?

Answer: The home has the responsibility to assure that residents' clothing is kept clean and in good repair. Exclusive of public pay residents, the facility sets its fees.

Standard 270

Clarification: If there is reason to question a resident's capability to understand and exercise his rights and responsibilities, as enumerated in Section 63.2-1808 of the *Code of Virginia*, the facility must obtain an opinion from a physician regarding this matter. If the physician determines that the resident is incapable of understanding and exercising his rights and responsibilities, documentation of the finding and the reason must be obtained from the physician. This documentation is to be filed in the resident's record.

Section 63.2-1808, Rights and Responsibilities of Residents of Assisted Living Facilities, is included as Attachment I in the ALF standards. The specific requirement referenced above may be found in Section 63.2-1808.

Standard 270.F

Question: The standard requires that the rights and responsibilities of residents shall be reviewed with all residents annually. Is this required for residents with serious cognitive impairments? Can the resident with a serious cognitive impairment sign (to indicate that he has been informed of his rights) and what is the responsibility of the facility?

Answer: An assisted living facility is responsible for reviewing the rights and responsibilities of residents with all residents annually including those residents with serious cognitive impairments. If the resident cannot sign to acknowledge having been so informed the rights and responsibilities should be reviewed with the resident's personal representative as well as with the resident and the representative can sign the acknowledgment.

March 1998

Standard 270.C

Question: Is use of reverse peepholes in doors of residents' rooms permissible? A facility wishes to use reverse peepholes to monitor the residents on a dementia unit at night when they are asleep.

Answer: A reverse peephole allows a staff person, or anyone else for that matter, to look into a resident's room without the resident having any control over when a person is looking in. The Code of Virginia, § 63.2-1808.A.17 (resident rights), states that each resident of an assisted living facility must be "… accorded respect for ordinary privacy in every aspect of daily living…" Reverse peepholes are a violation of this right and are therefore not permitted in assisted living facilities.

December 2001

Standard 270.E

Question: "The rights and responsibilities of residents shall be printed in at least 12-point type and posted conspicuously in a public place in all assisted living facilities." What is "posted conspicuously"?

Answer: The rights and responsibilities of residents must be displayed in such a way as to be easily located and read.

October 2001

Standard 275

Question: What would be on the UAI to indicate an individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare?

Answer: There are some indicators in Section 3 (Psycho-Social Status) of the Private Pay UAI and even more in Section 4 (Psycho-Social Assessment) of the Public Pay UAI although neither of these sections specifically address a resident's ability to recognize danger or protect own safety/welfare.

Question: Could the physical exam form be modified to include a question about whether an individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare?

Answer: No, the physical exam form currently only asks for information that is required in the Standards. Having a doctor's statement that a resident has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare is NOT required except for a resident with a primary psychiatric diagnosis of dementia in special care unit.

A model form has been developed for the assessment required by 700 C 1 (Assessment of Serious Cognitive Impairment [032-05-078/2)].

Question: If a person has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare, could he be considered ambulatory if he is physically and mentally capable of self-preservation by evacuating in response to an emergency with a single verbal command?

Answer: Probably most of these individuals would be considered non-ambulatory, but there could be the exception of a person who is capable of self-preservation by evacuating in response to an emergency with a single verbal command even though the individual has a serious cognitive impairment and cannot recognize danger or protect own safety/welfare.

Standard 275.C

Question: Does this standard also apply to special care units?

Answer: Yes, all residents shall be allowed access to common areas and their personal spaces. No resident shall be locked out of or inside his room.

Question: Does "personal spaces" mean residents' assigned rooms?

Answer: Personal spaces would include residents' assigned rooms and other areas such as a shared bathroom between two rooms.

December 2001

Standard 275

Question: Are ALFs allowed to lock doors to prevent access into the facility from the outside?

Answer: Yes. A facility may lock doors to prevent access into the facility as long as residents inside a facility (except those in a special care unit) are not locked in.

Question: If a resident is in his room, may he lock his door?

Answer**:** He may lock the door while inside the room if:

- the lock conforms to the Uniform Statewide Building Code;
- locking the door does not infringe upon the rights of a roommate;
- a key is readily available to allow staff access to the room;
- locking the door does not prevent staff from providing proper supervision; and
- he is not a resident with a serious cognitive impairment who cannot recognize danger or protect his own safety and welfare.

Question: If a resident is outside his room, may he lock his door?

Answer**:** He may lock the door when he leaves the room if:

- the lock conforms to the Uniform Statewide Building Code;
- locking the door does not infringe upon the rights of a roommate;
- a key is readily available to allow staff access to the room; and
- locking the door does not prevent staff from providing proper supervision.

Question: May a facility have a locked perimeter fence?

Answer**:** Only a special care unit may have a locked perimeter fence.

Standard 290

Question: The standard is unclear about who can make a determination that a resident not be allowed to make reasonable visits outside the facility.

Answer: A personal representative can either be a guardian, conservator or other person legally appointed by the court or representative expressly named by the resident to conduct his affairs. One of these persons must provide a written order if a resident is prohibited from visiting away from the residence.

Standard 310

Question: Does a monthly resident forum with agenda and luncheon count as a resident council?

Answer: Yes, there is no frequency set as long as the forum is a medium by which residents' concerns and issues are addressed.

Standard 330.C

Question: Residents may be capable of preparing their own meals although they may be dependent in an activity of daily living (ADL) or an instrumental activity of daily living (IADL). Does a dependency in one ADL or IADL mean that a resident is not permitted to prepare his own meals rather than obtaining them from the facility?

Answer: Standard 330.C is an exception to Standard 330.B which requires that all meals be served in the facility's dining area. A resident with "independent living status" has the option of obtaining meals from a source other than the facility if he has a properly equipped kitchen in his apartment. "Independent living status," as defined in the ALF regulation, means that the resident is capable of performing all ADLs and IADLs without the assistance of a staff member (see the definitions of ADLs and IADLs for included activities). Therefore, when a person needs the help of a staff member in one ADL or IADL, the person does not have "independent living status and thus does not have the option of preparing his own meals. However, because independence, individuality and fairness are among the guiding principles of the ALF regulation, an allowable variance should be considered when the resident is capable and desirous of preparing his own meals even though he does not meet the criteria for "independent living status."

February 1997

Standard 330.B

Question: Does “temporary” in this standard refer to both ILLNESS and INCAPACITY?

Answer: Yes, “temporary” does refer to both illness and incapacity.

Standard 380.F

Question: Residents are counseled by a registered dietician on diet. Food is available in the buffet for residents in need of therapeutic diet. Does this meet the provision of the standards?

Answer: If the home will make sure that the special diet is obtained, this would be acceptable depending upon the residents' ability to select appropriately from the buffet.

Standard 390

Issue: Is the requirement to ensure the availability of a 72-hour emergency drinking water supply reasonable? Some operators have reported problems with cost, storage, or locating an emergency coverage contractor.

Resolution: A facility must have a written emergency plan to meet the requirement for emergency drinking water or have an adequate supply on hand at the facility or have a combination of a plan and supply. Based on information provided by an expert at VPI & SU, a minimum of 6 cups of fluid, at least 3 of which must be water, must be available per resident per day for emergencies. The plan or supply has to be based on this minimum of 6 cups.

If other fluids are used for part of the supply or included in the plan, they are to be fluids, such as those juices, soups, etc. which consist basically of water. If a plan is used to ensure the availability of emergency drinking water from another source, the facility must have a written agreement with those who will supply the water.

Based on research in the Richmond area, a gallon of bottled drinking water (16 cups) costs from about 70 cents to 90 cents and is good for about two years. For 20 residents, based on 3 cups of water for 3 days, this translates into a cost of approximately $4.80 a year.

Question: Is there a list of amounts and types of food for emergencies?

Answer: The amounts and types are not specifically listed in the standards but foods should include those not requiring cooking or refrigeration and the amounts will be determined by the residents in care.

Question: Do you need water if generator is available?

Answer: The minimal allowance identified by disaster planning authorities is one gallon of water per resident per day. If generator ensures compliance, this is acceptable.

March 1998

Standard 390

Question: Can an assisted living facility use the water in the hot water tank or in the water tank behind a toilet to meet the requirement for a 72-hour emergency drinking water supply?

Answer: Based on the most current advice from the Virginia Department of Health, the following applies:

The water from the hot water tank can be used for emergency drinking water supply under the following conditions:

1. Sediments have been periodically flushed from the tank (at least annually, more often in areas subject to heavy sediment accumulation);

2. Water is collected from the tank in a sanitary fashion using sanitary containers and conduits; and

3. There are no cross connections or other plumbing hazards subject to activation by the loss of water pressure on the premises.

The water from the tank behind the toilet cannot be used for emergency drinking water, without boiling, because this tank is not a sanitary storage vessel. Water in this tank is no longer part of the water system and is subject to potential contamination and bacterial growth. Assuming no cleaners or deodorants have been added to the water in the toilet tank, this water could be used for emergency drinking water if heated to a rolling boil for at least one minute.

Since it is quite possible that in the event of an emergency there would be a power failure, it would be necessary to have available an alternate way of boiling water as specified above.

Water from the hot water tank or water from the toilet tank (boiled) is best used for non-consumptive uses, such as hand washing, if any better source of drinking water, such as bottled water, is available.

Standard 400.A

Question: Is the MAR from the pharmacy acceptable for the written order required to be in the resident's file or do facilities need a written order also? How would a facility get this written order since the original prescription is given to the pharmacy to file? Could a fax or copy of the prescription be used by the facility to meet this standard? A prescription will be written in pharmacist/physician's language. Is some additional instruction for the facility in addition to the prescription label needed by the facility?

Answer: A written order by the physician or a notation of a verbal order signed by the physician within 10 working days is needed in addition to the MAR provided by the pharmacy. One option is for the facility to obtain a duplicate or a copy of the prescription as written by the physician. The physician may provide a copy that is marked as a duplicate. The pharmacy may provide a copy of the prescription as written by the physician. Medication aides are taught to read prescriptions using the language and notations that physicians use. Other written types of documentation by the physician are also acceptable. If information is needed in addition to what is on the prescription, the physician should provide a written order with additional information.

Question: If a physician phones in to a pharmacist a change in medication, then does the facility have to get the signature of the physician with 10 working days? Does the fact that it was called into the pharmacy and the facility has the medication indicate approval?

Answer: The call to the pharmacy by the physician and the medication arriving at the facility do not meet this standard. See answer above.

Question: How do facilities get physician's orders if the doctor gives them to the pharmacy for filling of medication? Must the facility request a duplicate or ask the pharmacy to give them a copy?

Answer: A facility could ask for a duplicate prescription, could ask the pharmacy for a copy of the prescription, or ask the physician for a written order.

Question: If a pharmacy issues a MAR or the prescription information is on the medication container, is that sufficient for physician's orders or do homes need something else?

Answer: A MAR or prescription information on the medication container is not enough.
See answers above.

Question: If facilities need physicians' orders separate from MARs, must they go back and get ones on current medications for residents in care?

Answer: Yes. This is not a new requirement.

Question: If a physician calls Rx change (addition or discontinuance) to pharmacy, does the facility still need to verify and have written documentation from physician?

Answer: Yes. This approval could be faxed.

Standard 400.A & F.2

Question: Can residents take over the counter meds without MD order if the facility is responsible for administering the resident's meds?

Answer: No.

Standard 400.C

Question: Please advise of your recommendations re: residents of AL who can self administer. Must we have a locked box in a locked room?

Answer: If their apartment is locked they can keep medicines in their bathroom medicine cabinet. An additional lock is not needed.

Standard 400.D

Question: Can a facility buy over-the-counter medication in bulk for residents?

Answer: A facility may buy over-the-counter medication in larger quantities as long as a separate bottle/package is purchased for each resident using the medication. The bottle/package may not in any way be repackaged for individual residents. The original bottle/package should be identified as belonging to a specific resident. The same bottle/package may not be used for multiple residents. This is considered floor stock and is not allowed.

Question: How should sample medication given to the resident by the physician be handled?

Answer: The physician should provide a written order to the resident (or sign a notated verbal order within 10 working days) with information on using the sample medication. The sample should be identified by the facility as belonging to the resident.

Question: Can any injection other than insulin be administered by a medication aide?

Answer: No. The only injection that medication aides are taught to administer are insulin injections.

Question: Can nursing students enrolled in a nursing program administer medication in a facility?

Answer: Yes. Code Title 54.1 (Professionals and Occupations), Chapter 30, Section 54.1-3001 states that the practice of nursing prescribed as part of a study program by nursing students enrolled in nursing education programs approved by the Board of Nursing are exempt from licensure. According to the Board of Nursing these students can administer medication as part of their program of study. They are under supervision by their instructor or a preceptor. It is allowable for them to administer medication in our facilities.

Standard 400.D.2

Question: Are authorized agents considered licensed health care professionals, therefore able to administer medications under the new regulations? Also, can PRN medications be passed?

Answer: The term authorized agent is no longer used under the standards. Persons administering medications must have completed a medication management training class, but this training alone does not qualify them as "licensed health care professionals." PRN meds are prohibited in ALFs unless conditions 1, 2, or 3 of the standard (400H) are met.

Standard 400.D.4

Question: Do all meds have to be witnessed as taken when administered by ALF staff?

Answer: Yes.

Standard 400.H

Question: Can you keep a written order on the MAR for PRN medication that would cover distribution for a certain period of time, e.g., Tylenol?

Answer: You need a written order by the physician for PRN medication and the Division has provided a model form for this order. The MAR might also have information on use of PRN medication, but this does not constitute a physician's order.

Question: Does this plan have to be written?

Answer: There is no mention of the work plan in this standard. There has to be an order by a physician either in writing or a notation of a verbal order which has been signed by the physician within 10 working days in the resident's record before any medication can be used. If the resident is not capable of determining when the PRN medication is needed or if a licensed health care professional is not responsible for medication management, then the order needs to be in detail to cover the information in 400.H.3 or the facility has to call the doctor prior to administering the PRN medication.

Standard 400.H.1

Question: If the resident is capable of determining when medication is needed, but does not self- administer medication, can the resident still determine when PRN medication is needed?

Answer: Yes. The standard refers to the resident being capable of determining when the PRN medication is needed.

Question: Define "capable". Is verbalization of pain or discomfort "capable"?

Answer: If they have cognitive ability which may be determined on UAI.

Standard 400.H.2

Question: Can a CNA give PRN medications if certified to give oral medications?

Answer: A CNA has to successfully complete the Medication Management Training Program for medication aides in order to administer any medication (this includes PRN medication). In order to administer a PRN medication, the CNA must be informed by the resident that the PRN medication is needed, must have the resident's need for the PRN medication determined by a licensed health care professional (CNAs are not licensed health care professionals) who is responsible for medication management, or must have the resident's physician's detailed written instructions or documented oral order prior to administering the medication.

Question: Define licensed health care professional. Physician only?

Answer: Licensed health care professional here means physician, pharmacist, RN, or LPN.

Question: Does a licensed health care professional have to be present for a CNA to administer medication?

Answer: No, but the CNA has to have successfully completed the Medication Management Training Program for medication aides.

Question: Does the licensed health care professional responsible for medication management have to be present to determine the need for PRN medication?

Answer: If the licensed health care professional is other than a physician, he/she has to personally observe the symptoms that the resident is experiencing. The licensed health care professional might leave the facility and instruct staff to give PRN medication if symptoms continue as long as the instructions are specific and documented.

Question: Does a nurse on staff count toward this standard?

Answer: Yes. Any licensed health care professional, acting within the scope of his profession, counts.

Standard 400.H.3

Question: Physician has listed PRN (over the counter) medication that can be used on the History and Physical Exam. According to instructions on medication label (if every 4 hours) does this apply? Physicians will not write or want to be called for every Tylenol or Maalox given. Please clarify this standard.

Answer: It is not necessary to call if the physician includes on the H&PE or the model PRN form or some other way in writing the symptoms that might indicate the use of the medication, exact dosage, the exact time frames the medication is to be given in a 24-hour period, and directions as to what to do if symptoms persist.

Question: Traditionally, facility staff (e.g. CNAs) have not legally been able to accept verbal orders from physicians. Does this new regulation now make them legal or enable the CNA and others to call the physician and accept the verbal order?

Standard 400.H.3 (continued)

Answer: If the verbal order is for a prescription medication, the doctor or his staff must call in the order to the pharmacy. Facility staff (unless a licensed health professional) cannot call in an order for a prescription medication to a pharmacy. This is prohibited by the Drug Control Act.

Question: It has become somewhat difficult for facilities to have the last component, directions as to what to do if symptoms persist, included in the physician's order. One pharmaceutical company has begun putting a general direction in the PRN section that states to contact physician if PRN is ineffective, or if symptoms persist longer than 24 hours. Would this general statement meet this component of the standard?

Answer: No. The physician's order must stipulate what to do if symptoms persist.

Question: On the MAR, PRNs are printed out separately. Can they put a statement above the PRN if symptoms persist please notify the resident's doctor within 24 hours or sooner if needed?

Answer: Only if that is what the physician has ordered. The physician's order must stipulate what to do if symptoms persist.

Standard 400.I

Question: Is "no smoking" sign needed if facility is SMOKE FREE?

Answer: No additional sign is needed.

Standard 400.I.2

Question: How will "long" be defined and determined?

Answer: Will be determined with consideration for safety and based on professional advice.

February 1997

Standard 400.A

Question: What is the proper procedure for medication administration when a resident is temporarily transferred to a hospital and returns to the facility with new medications?

Answer: When patients are transferred from a hospital to an assisted living facility and were not discharged at the time of admission to the hospital, the following shall apply:

> A facility may only administer medications that are on a physician's order sheet. If any of the old medications are not on this order, the facility must contact the resident's physician to determine whether these medications are to continue under the present circumstances. This should be followed up with a physician order.

When patients are transferred from a hospital to an assisted living facility and were discharged from the ALF at the time of admission to the hospital, the following shall apply:

> The facility should administer only the medications which are contained on the physician's order sheet sent from the hospital as this scenario constitutes a new placement with all new information.

Standard 400.D

Question: Can a medication aide prepare an insulin-like injection for the resident to self-administer?

Answer: Insulin is the only injection in which Medication Aides may be involved.

August 1997

Standard 400.D.1

Question: Can a resident be both "self-administer" for some medications and "facility administer" for other M.D. ordered medications? Would this have to be assessed as part of the UAI?

Answer: Yes, it is possible for a resident to be able to self-administer some medications, but need facility staff to administer other medications. This would have to be assessed on the UAL In such a case, the most restrictive or limiting option is to be selected, that is, "Administered/monitored by lay person" or "Administered/monitored by professional nursing staff" (whichever is appropriate) would have to be checked. Since only one option is to be selected, the option of "Without assistance" is not to be checked under these circumstances. Instead, a note is to be made that the resident is able to self-administer certain medication(s) and those medication(s) must be specified.

For any medication administered by the facility, there must be an order by the physician.

March 1998

Standard 400.D

Question: How should a facility identify over-the-counter (OTC) medication or sample medication as belonging to a specific resident? If the facility puts the resident's name on the OTC or sample medication, is this considered labeling and is this a problem?

Answer: Over-the-counter medication or sample medication must belong to a specific resident. It must be in its original packaging which would include directions for use and other information on the medication. It must not be repackaged in any way or used for multiple residents. It is permissible to put the resident's name on the package/bottle. This is not considered labeling. Over-the-counter medication and sample medication need physician's orders.

Question: What information is required to be on the packaging for sample medication?

Answer: The sample must be in its original packaging with all information that comes with the original packaging. There must be physician's order with information on using the sample medication.

Standard 400.D.2

Question: Can the medication management training program be mental health medication training?

Answer: The Medication Management training program referred to in these standards must be the one approved by the Board of Nursing. The curriculum was last revised in September of 2000 and is maintained by the Virginia Geriatric Education Center at Virginia Commonwealth University.

Standard 400.D. and F

Question: A family member arranges for a private sitter, a person from home health, or someone else to provide care to a resident. The person who is providing care administers medication to the resident who is dependent in medication administration. Is this acceptable and does the facility have to keep documentation of the medications that were administered to the resident by this person?

Answer: If the facility keeps the medicine for the resident and is responsible for the resident's medication administration (whether the resident is capable of self-medication or not), then the facility staff must administer the medication and keep documentation. If the family member arranges for a private sitter, a person from home health, or someone else to provide care and also wants the care to include medication administration, the facility must give written permission for this to occur. The facility must also verify that the care giver is licensed by the Commonwealth of Virginia to administer medication or has successfully completed a medication training program approved by the Board of Nursing (Code of Virginia § 54.1-3408). There must be documentation of medication administration as required by the standards.

Standard 400.F.12

Question: Can there be a master reference list with the names and initials of all staff administering medications rather than including the name and initials on the documentation for each individual resident?

Answer: No.

October 1998

Standard 400.A

Question: Which assisted living facility staff members can take the physician's verbal orders for medications?

Answer: The staff members who are allowed to take the physician's verbal orders for medications are those who meet the requirements of Standard 400.D to administer medications. In order to take the physician's verbal orders for medications, the staff members must have successfully completed a medication training program approved by the Board of Nursing or be licensed by the Commonwealth of Virginia to administer medications. The verbal orders must be reviewed and signed by the physician within 10 working days. The verbal orders referenced here are those which the facility must have to start, change or discontinue a medication.

The standard has nothing to do with calling in oral prescriptions to a pharmacy. The Code of Virginia prohibits ALF staff from transmitting verbal orders to a pharmacy unless the staff meet certain criteria. The Code states that oral prescriptions must be transmitted to the pharmacy by the prescriber or an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid **license** allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

April 1999

Standard 400.A

Question: Can a physician's nurse, rather than the physician, transmit the physician's verbal order for medication to assisted living facility staff members who are allowed to take the verbal order?

Answer: A physician's nurse who is an authorized agent of the physician prescribing the medication may transmit the physician's verbal order for the medication to ALF staff members allowed to take verbal orders, however, ALF staff members (including nurses) may not call this order to the pharmacy.

Orders may be transmitted to the pharmacy only by the prescriber or his authorized agent. An authorized agent of the prescriber is someone in his direct and immediate employment, or a person who holds a valid license allowing the administration of drugs and who is specifically directed by the prescriber.

According to the Drug Control Act of the Code of Virginia, there must be no more than one person between the prescriber and the dispenser (the pharmacist), and that person must be an authorized agent as described above.

August 1997

Standard 410

Question: Would a licensed EMT, off duty as an EMT, who is an employee of an ALF be able to implement a DNR order?

Answer: Section 54.1-2901 of the Code of Virginia, which was amended and reenacted by the 1996 Virginia Legislature, provides for any employee of any ALF who is certified in cardiopulmonary resuscitation (CPR) and acting in compliance with a resident's individualized service plan and with the written order of the attending physician, to honor a resident's valid request not to be resuscitated in the event of cardiac or respiratory arrest. The 1996 Virginia Legislature also added Section 63.2-1807 to the Code of Virginia. This section states that owners and operators of ALFs may provide that their CPR certified employees not be required to resuscitate the residents identified above.

The changes to the Code of Virginia allow, but do not require, ALF employees who are CPR certified to honor a resident's valid request not to be resuscitated in the event of cardiac or respiratory arrest.

Standard 430

Question: Clarification is needed as to which incidents need to be reported to the licensing agency.

Answer: Incidents that have affected the overall operation of the facility or the health, safety or welfare of one or more residents should be reported to the licensing agency. Minor incidents need not be reported.

Question: Are the reported “incident reports” available for public viewing upon request?

Answer: Yes, except for names and personal information.

Standard 450

Issue: A statement or itemized receipt of a resident's account should be provided on request rather than monthly.

Resolution: There was agreement to leave the standard as it is until the next review cycle.

Question: If a resident is confused, can the monthly statement or itemized receipt be given to someone else?

Answer: The standard requires that a resident receive a monthly statement or itemized receipt unless the resident has a court appointed conservator or guardian.

Question: Resident accounts. Can the resident's detailed ledger account in an accounting system be considered the resident's record or does a hard copy of each monthly statement need to be printed out and put in the resident's file?

Answer: The resident must be provided a hard copy. As long as the accounting system meets the requirements of being part of the resident's record, e.g., resident specific, readily accessible, a hard copy for the record is not necessary.

February 1997

Standard 450

Question: Is hard drive on the computer or a disk sufficient for the monthly statement or itemized receipt of the resident's account? The information can be obtained for each resident from the computer. The bill can be generated at any time.

Answer: The resident must be provided a hard copy of the statement or itemized receipt on a monthly basis. Maintaining the account on a computerized system is acceptable as long as the requirements for a resident's record are met, e.g., resident specific and readily accessible.

October 1998

Standard 450

Question: Can the facility give the monthly statement or itemized receipt of the resident's account to a person who has power of attorney to handle the resident's finances, rather than to the resident?

Answer: The facility must give the monthly statement or itemized receipt to the resident. The assisted living facility can *also* give the monthly statement or itemized receipt to a person who has power of attorney to handle the resident's finances when that person is executing the payments to the facility. The statement or receipt given to the person who has power of attorney may only include those items for which he or she is responsible for payment.

Standard 470

Issue: Consider eliminating the use of restraints or putting more limits on their use, avoid defining bed rails as a restraint, and give more training and materials to providers on alternatives to the use of restraints.

Resolution: The ALF standards regarding restraints are based upon the Health Care Finance Administration's regulations on restraints, except that chemical restraints are prohibited in ALFs. The ALF standards on restraints are similar to those found in the proposed regulations for the licensure of nursing homes, except for chemical restraints and emergency restraints (ALF standards require a resident to be transferred to a medical facility or monitored by a mental health crisis team if the emergency restraint is necessary for longer than two hours). The conclusion was that the ALF standard on restraints is fine as it is.

If a resident cannot remove a bed rail easily and it restricts freedom of movement or access to his body, the bed rail is by definition a restraint. A half bed rail may or may not meet the definition of a restraint. Suggestions were made to be sure facilities document in the service plan when a half bed rail is not a restraint and to make sure licensing staff understand that a half bed rail may or may not be a restraint, depending on the resident's agility or strength.

Standard 470.B.2

Question: Can a resident who is cognitive request and authorize the use of bed rails? If so, can they sign a written consent that documents this request?

Answer: If the bedrail is a physical restraint (see definition), there must first be a physician's written order. Also, the facility must first obtain the written consent of the resident or if appropriate, his personal representative. If there are 1/2 rails which the resident can get around without difficulty to get out of bed or the bed rails can be easily released by the resident, the rails would then not be considered a restraint and a physician's order would not be necessary. If not a restraint, a written consent by the resident would not be required, although it might be advisable.

Standard 470.C

Question: Do restraints have to be checked every 30 minutes even when resident is asleep? For bed rails? Does check need to be documented? Are 90 day reports required?

Answer: Yes, residents must be checked even if asleep (not necessary to awaken resident). If a bedrail is a restraint, the requirements for restraints apply. Checks must be documented. 90 day progress reports are no longer required.

August 1997

Standard 470

Question: Shouldn't there be something on the model physical examination form about restraints? If not, should there be a model form for ordering restraints?

Answer: The ALF standards call for the reduction or elimination of the use of restraints. To assist in accomplishing this end, we do not think it would be appropriate to suggest the use of restraints or make it easier for physicians to order restraints by including them on a model form.

April 1999

Standard 470.C.5 and 7

Question: Standard 470.C supports restraint reduction through utilization of assessment and service plan review. When putting these standards in context with Standard 470.B regarding the physician required order, should there be revised physician orders every time staff attempts to reduce usage of the original restraint? Compliance insights would be helpful.

Answer: The physician should be encouraged to write the order in such a way that appropriate reduction in restraint use is clearly identified. Otherwise it would be necessary to notify the physician for a revision in the order before restraint use is altered.

Standard 470.D

Question: Are the PRN orders for residents of ALFs which state that the medication is to be given for aggressive behavior considered "chemical restraints?"

Answer: If the medication is being used for discipline or convenience and not required to treat the resident's medical symptoms, it is a chemical restraint. Chemical restraints are prohibited in ALFs by Standard 470.D.

The reason for the aggressive behavior is critical in determining whether or not the medication is a restraint. There are many causes of aggressive behavior. It is important to note that aggressive behavior is very subjective and involves internal as well as external factors. The cause of aggressive behavior must not be left to be determined by unlicensed assistive personnel. Standard 400.H specifies requirements regarding PRN medications.

Drugs used to control aggressive behaviors are potent drugs, with many side effects. They have high incidences of addiction and abuse. They may be used only when there is just medical cause.

Standard 480

Question: What are the qualifications needed for training on aggressive behavior? Can ALF staff who were trained to be trainers continue to train on this topic?

Answer: The trainer for aggressive behavior must be a qualified health professional. Qualified health professional is defined here as a R.N., L.P.N., psychologist, social worker, counselor, or other health professional who has knowledge of and experience working with people with aggressive behaviors. This professional does not have to be licensed. This professional does not have to have been trained as a trainer using an aggressive behavior curriculum. The Department offered a train- the-trainer series on aggressive behavior in 1991. Apparently it was not required that the people attending this training be qualified health professionals, however the standard at the time clearly stated that trainers had to be qualified health professionals. If current staff of ALFs who are not qualified health professionals were trained as trainers and are currently providing training to staff, they may request an allowable variance to continue conducting the training.

Question: Restraint training for staff - can it be done by a RN on staff?

Answer: Restraint training must be provided by a qualified health professional. A RN is a health professional. If the RN on staff has expertise in restraints, he/she could provide the training to staff.

Question: Do you have to provide training if restraints are not used?

Answer: Restraint training must be provided to staff only if they are involved in the care of residents with whom restraints are used.

Standard 480.3.a

Question: We were told in training that staff trained as Aggressive Behavior Trainers would be grandfathered for Standard 480.3.a if they were not qualified health professionals. We informed providers of this in the training.

Answer: Nothing has changed with this standard. Both old and new standards require training by a qualified health professional.

Standard 490

Question: Does changing from the I-1 Use Group to the I-2 Use Group constitute a change of Use Group?

Answer: Yes.

Question: If an assisted living facility classified in the R Use Group is sold would it have to be re-classified into the I-1 Use Group?

Answer: Not if it continues as an assisted living facility and no renovations are made that would affect the Use Group classification.

Question: Do all newly constructed assisted living facilities have to have a sprinkler system?

Answer: Yes.

Question: If an ALF that was classified as an I-2 facility was built at the time that it was not required to have a sprinkler does it have to be retrofitted?

Answer: Not if continues to be used as an assisted living facility.

Standard 490.J

Question: Do you have a formal list of what you consider as a weapon?

Answer: No.

August 1997

Standard 510.C.2

Question: Is this standard applicable to fireplaces? Does licensing approve wood burning and gas log fireplaces in ALFs approved for the assisted living level of care?

Answer: Standard 510.C.2 does not address fireplaces and is not applicable to fireplaces. The Virginia Statewide Fire Prevention Code has no restrictions on the use of fireplaces. The building code only addresses the construction of fireplaces. Therefore, if fireplaces are built properly, they are acceptable in all ALFs. They do not pose the same safety threats as space heaters or portable heating units. If a facility has a fireplace and it poses a safety threat to residents who might fall into it or put a hand or foot into it, then that situation would need to be dealt with as a safety issue and the appropriate standard(s) applied. The same would be true of a possible health hazard to residents from smoke or fumes, particularly to those persons with any significant breathing problems or a tendency to develop such. Moreover, the wrong kind of wood, e.g., scrap paneling, may give off toxic fumes.

Standard 530.2

Question: Wording should be changed to read "…change in use group as determined by the local building official..." because applicants are not always going to the building official to make this determination and are relying on licensing staff to do so.

Answer: The building official is the only person who can determine that a change of use has occurred or needs to occur. Applicants should be referred immediately to the building official if they are considering purchasing or leasing property for use as an assisted living facility.

Standard 530.4

Issue: Reword the standard so that it is clear it means uncovered glass since part of the "glazed" window area may be covered with wood or some other material.

Resolution: The required square footage of window area must be exposed clear glass, which does not include window frames. There was agreement to wait until the next review cycle to make the wording clearer.

Standard 550.B

Question: Are cloth towels acceptable in the bathrooms instead of paper towels?

Answer: No. Common hand washing washbasins must have either paper towels or an air dryer.

August 1997

Standard 550.B

Question: Define “common hand washing washbasins.”

Answer: It is easier to define “common hand washing washbasins” by what they are not than by what they are. A sink that is accessible only to residents of one or two bedrooms or a sink that is in a private apartment is not a common hand washing washbasin. All other sinks are considered to be common hand washing washbasins.

February 1997

Standard 570

Question: Do fire prevention officials know they are supposed to approve the fire plans in ALFs?

Answer: The *Virginia Statewide Fire Prevention Code* requires that assisted living facilities in the I-1 and I-2 Use Groups have an evacuation plan. The review of the evacuation plan should be part of the inspection that is done by either the State Fire Marshal or the local fire prevention authority. The *Virginia Statewide Fire Prevention Code* does not require an evacuation plan for R Use Group facilities; however, the ALF standards do require a fire plan for all facilities. A facility should make its licensing inspector aware of any problems with obtaining the approval of the appropriate fire prevention official.

Standard 580.A

Question: What does “practice” mean in this standard? In building with I-2 classifications, residents don’t get up (move) when the fire alarm sounds. Doesn’t this standard require that they at least move to their designated area?

Answer: “Practice” means to practice meeting the requirements of the approved fire plan, whatever they may be.

Standard 580.F

Issue: When there are confused residents in care, can we accept some other signaling device than the usual fire alarm because the noise is upsetting to confused residents?

Resolution: The requirements of the Statewide Fire Prevention Code apply to ALFs. These requirements address the types of fire alarm signals that are acceptable and the minimum level of sound. There appear to be options that would not be as upsetting to confused residents as the usual fire alarm. ALFs that desire assistance on this matter should speak with their fire marshal about the options available to them. Whatever fire alarm the fire marshal finds acceptable is acceptable to us.

Standard 620.A

Question: Does the fire marshal have to approve an outdoor smoking area?

Answer: No.

Question: Do you have to have an area for required smoking or can your facility be non-smoking?

Answer: The facility can be non-smoking if it is so stated in the agreement that is required by Standard 150.T.

February 1997

Standard 620

Question: Do fire prevention officials know they are supposed to approve the designated smoking areas in ALFs?

Answer: Fire prevention officials will probably not designate a smoking area for a facility. If the facility has such an area, staff shall ask the fire prevention official to look at the area. The Virginia Statewide Fire Prevention Code prohibits smoking where conditions are such as to make smoking a hazard.

Standard 630.A

Issue: A grandfathered assisted living administrator should be able to become the administrator of another facility and still be grandfathered.

Resolution: An administrator of a facility employed prior to the effective date of the standards (February 1, 1996) is grandfathered. It was decided that the allowable variance process may be utilized to allow a grandfathered administrator to become the administrator of another facility and still be grandfathered. More consideration will be given to this matter to determine if there is another way to allow this without an allowable variance.

Issue: A person who exceeds the educational requirements of the standard but lacks the required year of experience in caring for adults with mental or physical impairments in a group care facility should be able to be hired as the administrator of an ALF licensed for assisted living care.

Resolution: In order to allow a person who exceeds the educational requirements of the standard but lacks the required year of experience to be hired as the administrator of an ALF licensed for assisted living care, the allowable variance process may be utilized for the period of time until the experience requirement is met. Through the allowable variance an administrator can be allowed to obtain the year of experience while on the job when he is adequately supervised by a trained professional who meets the qualifications for an administrator.

Standard 630.B

Issue: Clarify and/or revisit the question of when an assistant administrator must meet the administrator qualifications for an assisted living care facility.

Resolution: For assisted living care facilities, the assistant administrator does not need to meet the increased assisted living requirements unless he is acting in place of the administrator for 15 or more of the required 40 hours per week or for four or more weeks due to the vacation or illness of the administrator.

If the administrator attends conferences or training sessions, he will be considered as still performing as an administrator, therefore, the time spent at conferences or training sessions will not count against the required hours per week. However, more extensive education such as enrollment in a college course or certificate program will count against the hours.

The weeks due to vacation or illness will be interpreted as four consecutive weeks.

These above interpretations will allow the designated assistant administrator to act in place of the administrator for extended periods of time without having to meet the qualifications of the administrator.

Standard 630.C

Issue: What are the minimum contact hour requirements for ALF offered training for direct care staff? Is a person trained in a curriculum approved by DSS considered qualified if he goes to a different facility?

Resolution: The minimum contact hour requirement for the training is 40 hours. The content of the training is based upon the DMAS personal care aide training course. DMAS has informed us that based on its experience it takes at least 40 hours to adequately cover the curriculum.

A person who completed an ALF offered direct care staff training course approved by DSS would be considered qualified (regarding the training) if he goes to another facility when that person brings to that facility: 1) documentation showing that the ALF offered training had been successfully completed, 2) a copy of the written confirmation from DSS to the facility where the course was taken indicating that the training had DSS approval at the time the person took the course, and 3) documentation that the training was provided by an appropriate licensed health care professional.

Issue: An administrator should be able to teach the curriculum for ALF offered direct care staff training as long as the trainees are tested by a licensed health care professional. Also licensed nursing home administrators should be considered licensed health care professionals.

Resolution: The direct care staff training curriculum is based on the DMAS personal care aide training course which must be taught by an RN. The ALF regulations have broadened to licensed health care professionals those who can teach the direct care staff training curriculum. This allows LPNs and several others, as well as RNs, to teach the course when it is within the scope of their professions.

The licensed health care professional has full responsibility for maintaining the integrity and quality of the course and for being accountable for the instruction given. The licensed health care professional may make limited use of the expertise of others, both within and outside the facility. In other words, it is acceptable for additional resources to be utilized by the licensed health care professional on a limited basis if that person wishes to do so and deems that the resources would be appropriate. These additional resources include the facility administrator as well as others who have relevant expertise. The licensed health care professional must always remain in charge of and responsible for the way the curriculum is taught and must ensure that the content of the course is covered in a correct and thorough manner.

The educational requirements for licensed nursing home administrators focus on the administrative aspects of operating a facility. The training is not geared to the clinical "care" of residents, nor to the specifics of health related issues. Licensed nursing home administrators have expertise in administration, but they are not considered to be licensed health "care" professionals.

Question: Does a certified nurse aide mean State Board Licensed Nurse's Aide or can the staff have a certificate of training from a nurse's aide program?

Answer: Certified nurse aide means registration as a certified nurse aide with the Virginia Board of Nursing. However, if a person has graduated from a Board of Nursing approved educational curriculum from a Virginia Board of Nursing accredited institution for nursing assistant, geriatric assistant or home health aide, this is also acceptable as meeting the standard.

Standard 630.C (continued)

Question: With the CNA curriculum, can a licensed R.N. teach the course for their certification? If not, where are these courses?

Answer: This standard allows for a licensed R.N. to provide the 40 hours of direct care training that will meet this standard (as an alternative to the CNA) as long as the course is approved by your licensing inspector. Questions on the CNA curriculum should be referred to the Board of Nursing.

Question: Have you ever heard of a Certified Medical Assistant (CMA)? A CMA is supposedly of a higher skill level than a CNA. Would we accept a CMA in place of our requirement for a CNA?

Answer: CMAs are not regulated in Virginia. We cannot accept a CMA in place of a CNA.

Standard 630.J

Issue: Because of the expense, can the Health Department provide the required health care oversight for the ALF at no charge?

Resolution: It may be possible for an ALF to contract with the local health department for a public health nurse to provide the required health care oversight. However, it is unlikely that the service would be provided by the health department at no charge. In respect to auxiliary grant recipients, the ALF is already getting paid for the health care oversight through the additional payment(s) for assisted living care. It was agreed that more information about the effects of this standard will be collected by the next review cycle.

Question: Can the licensed health care professional referenced in this standard be the facility administrator?

Answer: Yes.

Question: Can a LPN or RN employed by the facility be the licensed health care professional to provide the health care oversight?

Answer: Yes.

February 1997

Standard 630.A

Question: A former administrator is currently working as a direct care staff. The facility wants to name her as administrator, but she does not meet the requirements. Does "employed prior to the effective date of the standards" mean any time prior for the exception?

Answer: No. The person had to be employed on January 31, 1996 as the administrator of the ALF in order to meet the exception. The intent of this section is to grandfather those administrators who were employed at the facility on January 31, 1996. Should these administrators change positions, they are no longer grandfathered and must meet the requirements of this standard.

Standard 630.C.4

Question: If a facility is using the Direct Care Staff Training Curriculum developed by the Department of Social Services, does it still have to have the curriculum approved?

Answer: The curriculum does not have to be approved, but the facility does have to submit a form [032-05-102], or another document with the same information, giving the identifying information of the facility, indicating that the Department's curriculum is being used, indicating the number of hours of instruction if the number varies from the Department's curriculum recommendation, and providing the name and professional status of the trainer.

Question: If a facility has submitted information on an instructor and a curriculum that the instructor uses (not the Department's curriculum) and the instructor and curriculum are approved, does there have to be another comprehensive review of the instructor and the curriculum if another facility is using the same?

Answer: No. However, the second facility must submit a form [032-05-102] or another document with the same information to obtain its own approval. If information is available and verified (from the facility, the instructor, or in the licensing office) that the instructor and curriculum have already been approved, the inspector may make the approval without a comprehensive review. It has been brought to our attention that an instructor that has been approved and has her own curriculum is planning to advertise and offer classes to staff in several facilities. This is fine as long as each facility submits a form indicating that it is using the instructor and her curriculum.

Clarification: In response to a question, we previously stated that a staff person who completed an ALF-offered direct care staff training course approved by DSS would be considered qualified (regarding the training) if he goes to another facility (specific documentation was required). We wish to clarify here that although the staff person would be considered qualified, an ALF may choose to retrain the person totally or retrain in specific areas. In other words, the ALF does not have to accept the person's previous training, either in whole or in part, and it can require the staff person to receive training in its own DSS-approved course. This might be particularly important if the populations of the two facilities differ significantly and different content areas are emphasized in the two curriculums.

February 1997

Standard 630.J

Question: Does this standard apply only to assisted living care residents, or to all residents in the facility?

Answer: This standard applies only to assisted living care residents. ALFs are licensed to provide residential living care or residential living care and assisted living care. Any facility licensed for assisted living care is also licensed for residential living care. When the two co-exist in the same facility, the assisted living care standards apply only to assisted living care residents.

Standard 630.J.6

Question: Can a registered nurse (RN) or licensed practical nurse (LPN) perform the quarterly review of medications?

Answer: Yes. An RN or LPN can perform the quarterly review of medications, which involves assessing that services are being provided in accordance with physicians' orders and informing the administrator of any problems.

August 1997

Standard 630.E

Question: Will the skills checklist referenced in this standard carry over from one facility to another?

Answer: No. The skills checklist was used to "grandfather" in existing direct care staff employed prior to February 1, 1996. If the staff person stays in the facility where "grandfathered," it is not necessary (but is desirable) for the person to go through the direct care staff training. If the person leaves one facility and is employed by another facility, the person must go through the training, within the first four months of employment at the new facility.

Standard 630.J

Question: The nurse LPN in a small home does the ISP, keeps records, directs the staff, is the owner/administrator, and then also is the licensed health care professional reviewing all the things that she has done. Is this acceptable?

Answer: In a situation such as this, when one person is directly responsible for all or most of the functions being reviewed by the licensed health care professional, it would not be acceptable for that person to be the licensed health care professional who provides the health care oversight.

Standard 630.J.5

Question: What is "intensive assisted living services?"

Answer: "Intensive assisted living services" is defined in Department of Medical Assistance Services (DMAS) regulations entitled *Assisted Living Services for Recipients Receiving Auxiliary Grants Residing in Adult Care Residences* (12 VAC 30-120-Part VII). "Intensive assisted living services" means services provided under the Social Security Act, Section 1915(c) waiver program to persons who have been determined to be at risk of nursing facility placement in the absence of home-and community-based waiver services such as those provided in an assisted living care facility. An individual who is assessed as needing intensive assisted living services has a functional capacity that is described by one of the following:

(1) dependent in four or more (of seven) activities of daily living (ADLs),

(2) dependent in two or more ADLs and has dependencies or semi-dependencies in a combination of behavior and orientation, or

(3) semi-dependent in two or more ADLs and has dependencies in a combination of behavior and orientation.

March 1998

Standard 630.A

Question: Can a grandfathered assistant administrator become a grandfathered administrator?

Answer: No.

Standard 630.A

Question: What is the equivalent of one year of college education in semester hours?

Answer: One year of undergraduate college education is equal to 30 credit hours. Credit hours and semester hours are the same, that is, 30 credit hours are equal to 30 semester hours. A full-time college student generally takes 10 courses (5 each semester) in one year since a typical course is three credit hours.

Standard 630.C

Question: How would staff who are EMTs be considered for direct care staff under Standard 630.C? This training is not specifically addressed so would they have to complete Standard 630.C.4, department approved ALF training?

Answer: EMTs have to go through the department approved ALF Direct Care Staff Training unless they also meet Standard 630.C. 1, 2, or 3.

Standard 630.E

Question: Can the skills checklist still be used?

Answer: The skills checklist is part of the department's Direct Care Staff Training Curriculum. It can be used as part of that curriculum. Standard 630.E was only in effect until February 1, 1997.

Standard 630.H

Question: Does the training under Standard 630.C.4, if taking place after the person has been employed, count toward the annual training requirement?

Answer: Yes, however, other training requirements (if required for the individual staff member and not covered in the ALF Direct Care Staff Training) must also be met. For example, Medication Management training, First Aid and CPR training, training on aggressive behavior and restraints which covers required content not covered in ALF Direct Care Staff Training, etc.

March 1998

Standard 630.J

Question: Does a licensed health care professional who is hired on a contractual basis have to meet requirements for staff, such as tuberculosis testing and criminal record checks?

Answer: Yes. The Regulation for Criminal Record Checks for Assisted Living Facilities and Adult Day Care Centers defines "employee" as compensated personnel working at a facility regardless of role, service, age, function or duration of employment at the facility. Employee also includes those individuals hired through a contract to provide services for the facility.

Standard 110.C. of the ALF regulations requires tuberculosis testing for each staff member. A licensed health care professional, whether hired directly or on a contractual basis, is a staff member.

Standard 630.J

Question: Is it acceptable for a person who is not a licensed health care professional to assist the licensed health care professional? The licensed health care professional would be responsible for all the functions listed in the standard, but some of the functions could be performed or partially performed by a person who is not a licensed health care professional.

Answer: The standard requires that the licensed health care professional provide the health care oversight and lists the functions that are the responsibilities of the licensed health care professional while on site at the assisted living facility. The licensed health care professional must perform the specified functions in order to ensure that the health care oversight is provided by a qualified individual. The licensed health care professional cannot delegate the tasks to someone who is not a licensed health care professional.

Standard 630.J.1

Question: Can a staff person who completes a resident's individualized service plan perform the oversight function of reviewing the plan and recommending changes?

Answer: Yes, it is acceptable for the staff person to perform this oversight function as long as he or she is a licensed health care professional, acting with the scope of the requirements of his or her profession, and the staff person is not directly responsible for all or most of the functions listed in Standard 630.J. As noted in the answer to an earlier question, when one person is directly responsible for all or most of the functions being reviewed by the licensed health care professional, it would not be acceptable for that person to be the licensed health care professional who provides the health care oversight.

March 1998

Standard 630.J.2

Question: Does the health care professional need to observe every direct care staff person?

Answer: The licensed health care professional must monitor, at least on a quarterly basis, the performance of all direct care staff in regard to health related activities. Monitoring direct care staff performance may be performed by 1) direct observation of direct care staff while they are involved in health related activities, 2) talking to residents and observing their conditions, and 3) reviewing facility procedures, resident records and other documentation. It is not required that each of these methods be utilized on a quarterly basis for each direct care staff person. However, direct observation of staff is a critical element in monitoring performance and therefore, at least quarterly, the licensed health care professional is to directly observe the majority of the direct care staff, including any direct care staff person where problems might be indicated. Direct care staff members on shifts where most of the health related activities occur should be directly observed by the licensed health care professional more often than those on duty at other times; however all direct care staff must be directly observed periodically.

April 1999

Standard 630.K

Question: Can a family member of an ALF resident perform skilled nursing treatments for the resident when the family member has been trained to do so by an appropriate licensed health care professional?

Answer: A family member of an ALF resident cannot perform skilled nursing treatments for the resident. Family members can be trained to give care in their homes because their homes are not governed by a regulating body. This is not the case in ALFs.

December 2001

Standard 630.C.4

Question: Will there be any changes to the Direct Care Staff Curriculum to reflect the changes in the Standards, e.g., will "dementia" be changed to "serious cognitive impairment?"

Answer**:** The curriculum will be reviewed and modified as necessary.

Standard 640

Question: Are the requirements in this section on the UAI?

Answer: Some are; some are not.

August 1997

Standard 640

Question: "Prior to or at the time of admission" - do individuals who were residents prior to February 1, 1996 have to have the information required in this standard? The same question relates to 150.S and T.

Answer: Individuals who were residents prior to February 1, 1996 do not have to have information required by the above three standards that is in addition to the information required by the previous assisted living facility (adult care residence) (home for adult) standards. (These residents do have to have all the information required by the previous standards.) However, it is advisable that the additional information specified in the three standards be obtained for individuals who were residents prior to February 1, 1996 since this would benefit both the facility and the residents.

Standard 650.A

Question: If a resident with mental illness goes to a day program, does that count toward the 14 hours of required activities?

Answer: Yes.

Question: Is what they do while away at the program the determinant for whether the program counts?

Answer: Yes.

Standard 650.B

Question: How will we know that staff have been trained in restorative and habilitative care? There does not appear to be a requirement that the training be documented.

Answer: Any training that we recognize must be documented in personnel files or staff development records. The title of the training, the instructor, place of training, date of training, and number of hours of training should be recorded for each staff person trained.

Standard 650.D

Question: Would a facility be in noncompliance if the documentation required by this standard is someplace other than in the service plan?

Answer: Yes.

Standard 650.I

Question: Does the annual review of all medications of each resident refer to residents with assisted living care status only or all residents?

Answer: Assisted living care status only residents are the ones who need to have all of their medications reviewed annually.

Question: If medications are on a computer printout from the pharmacy, and are reviewed, signed and dated by the physician, would this requirement be met?

Answer: Requirement would be met if done on an annual basis.

February 1997

Standard 650.I

Question: What must be included in the annual review of all the medications of each resident?

Answer: The following must be included in the annual review of all the medications of each resident:

1. All medications that the resident is taking and medications which he could be taking if needed (PRNs) must be reviewed. A "moment in time" review of the current regular routine and PRNs is required rather than a review of all the medications taken over the past year. However, if there are problems, it may be necessary to look back into the past year.

2. The review must include both prescription and over-the-counter medications. All the resident's medications must be reviewed. It is the responsibility of the assisted living facility to ensure that the licensed health care professional performing the annual review is aware of all of each resident's medications.

3. The review must be done for all assisted living care residents, that is, those for whom the facility administers medications and those who self-administer medications.

4. Looking at the dosage, strength, route, and how often the medication is taken must be part of the review.

5. Actual or potential interactions of drugs which do not or may not work well together are to be documented.

6. Consideration is to be given of whether PRNs, if any, are still needed or if clarification regarding use is necessary.

7. The review must include looking at whether additional monitoring is necessary for a specific medication and making sure the facility is aware of this, such as when insulin is used, blood sugar tests are being done as necessary.

8. Actual or potential adverse effects or unwanted side effects of specific medications are to be documented.

9. Identification is to be made of that which appears questionable so that the facility can follow-up appropriately. Examples of this might be: a) similar medications being taken, b) different medications being used to treat the same thing, c) what seems an excessive number of medications, d) what seems an exceptionally high drug dosage.

The licensed health care professional performing the review may choose to include elements in addition to those specified above in the annual drug review. For example, the licensed health care professional may decide to review all of the medications taken by each resident over the past year.

Standard 650.I (continued)

It is the responsibility of the assisted living facility to contact the licensed health care professional to schedule the annual review. The annual review can take place in the assisted living facility, in the pharmacy, or in the physician's office as long as it can be done in a thorough and accurate manner.

Question: Which licensed health care professionals, acting within the scope of the requirements of their professions, may perform the annual review of all the medications of each resident?

Answer: The licensed health care professionals who may perform the annual medication review are physicians, pharmacists, and licensed nurse practitioners. Board of Nursing staff have advised us that registered nurses who are experienced in administering the medications under review also may perform the annual review. However, it would not be appropriate for licensed practical nurses to perform the annual review. We have been advised by Board of Medicine staff that a physician may allow a physician assistant under his supervision to perform the annual medication review pursuant to the physician assistant's approved protocol.

August 1997

Standards 650.B and 650.D

Question: How should these two standards be linked to the service plan? It seems that there is some pretty extensive training required for staff with this standard. And how will facility staff and licensing staff determine the extent of the need for the restorative and habilitative care? How will the licensing inspector determine compliance with this standard?

Answer: Restorative and habilitative service needs are to be included on the individualized service plan (ISP). They are likely to be incorporated as part of other assessed needs rather than be listed separately as needs in and of themselves. Facility staff are to determine the extent of the need for restorative and habilitative care from the UAI, physical reports, communication with the resident, observation of the resident, and information provided by others, such as case managers, health care providers, psychologists, and relatives. The licensing inspector will determine compliance with these standards by looking at the UAIs, physical examination reports, ISPs, by talking to ALF staff and residents, by observing residents, etc.

Standard 650.F

Question: Does an M.D. have to order "restorative nursing?"

Answer: Restorative care is defined in Standard 10 and addressed in Standards 650.B, C, and D. No orders are required for restorative care.

Standard 650.F refers to rehabilitative services rendered by a rehabilitative professional. Rehabilitative services is defined in Standard 10 and addressed in Standards 650.E., F, and G. A rehabilitative professional is a physical therapist, occupational therapist or speech-language pathologist. Rehabilitative services must be prescribed by a physician or other qualified health professional.

Standard 650.I

Question: Does M.D. review of individualized service plan every 6 months meet the requirements of standard 650.I? How often by regulation should M.D. review the individualized service plan?

Answer: An M.D. is not required to review individualized service plans. Individualized service plans must be reviewed and updated at least once every 12 months and must be reevaluated as needed as the condition of a resident changes (See Standard 170.H). It is advisable, although not required, that the resident's physician be informed and involved as needed regarding the review or reevaluation of the plan. For assisted living care residents, a licensed health care professional, at least on a quarterly basis, must recommend changes to resident's service plan when the plan does not address the health care needs of the resident (See Standard 630.J.1). A licensed health care professional may be, but need not be, a physician.

Standard 650.I requires that a licensed health care professional, acting within the scope of the requirements of his profession, perform an annual review of all the medications of each assisted living care resident.

Standard 650.I (continued)

Question: If a resident self-administers medication and is seen every 6 months by his attending physician, does this meet the qualifications for the medication review?

Answer: If the physician includes all of what is required for the annual medication review (see Technical Assistance Insert to *The Standards Bearer, February 1997*), then the requirement that a licensed health care professional perform an annual review of all the medications of the resident would be met. The results of the review must be documented, signed and dated by the physician and any potential problems must be reported to the ALF administrator.

Standard 660

Question: Psychiatric or psychological evaluation. Does Alzheimers or any dementia come under requirement for current need or report from psychiatrist or a psychological evaluation -- has to be with UAI?

Answer: 660 applies to residents with mental illness or MR or SA, not Alzheimers/Dementia.

August 1997

Standard 660.A

Question: This standard addresses applicants for admission but what about residents already in care? Can an evaluation be obtained to determine continued appropriateness of care?

Answer: This standard only addresses applicants for admission, not residents already in care. However, Standard 150.A states, among other things, that no resident shall be retained for whom the facility cannot provide or secure appropriate care. In order to determine what is continued appropriate care it may be necessary to obtain a current psychiatric or psychological evaluation.

March 1998

Standards 660-690

Question: What is the definition of mentally ill?

Answer: The Code of Virginia, Section 37.1-1, states "*mentally ill*" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment...." According to the Department of Mental Health, Mental Retardation and Substance Abuse Services, a mental illness diagnosis can be made by a physician or other mental health professional in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

March 1998

Standard 680.A

Questions: Are progress reports needed if a resident sees a psychiatrist only for medication management and review, not for therapy?

Answer: Medication services are a type of service which may be received from the local community mental health, mental retardation and substance abuse services board, or a public or private mental health clinic, treatment facility or agent. As such, the standard requires written progress reports for a resident who sees a psychiatrist only for medication management and review.

Standard 700.B

Question: Can video tape series count as training?

Answer: Yes. A video tape series can count as training as long as it is facilitated by someone with verifiable expertise on the course topic and who can provide guidance as needed. The video tape series must have been developed by a qualified health professional or by a licensed social worker, must be relevant to the population in care and shall include, but need not be limited to:

a. Explanation of cognitive impairments;
b. Resident care techniques;
c. Behavior management;
d. Communication skills;
e. Activity planning; and
f. Safety considerations.

The training must be documented.

Question: Can this be in-service by the home's administrator?

Answer: Yes, however, the curriculum used by the administrator must meet the criteria listed above.

Question: Do the curriculum requirements above apply to 700.B.4 and/or B.6?

Answer: The curriculum requirements in 700.B.5 refer to 700.B.3.&4. 700.B.6 requires one hour of orientation for new staff on the nature and needs of residents with cognitive impairments relevant to the population in care.

Question: Does the Department's training on dementia count toward this requirement? What about area Alzheimer Association training or other resource? How would we know if the curriculum has been developed by a health professional if given by a community group?

Answer: The Department's training. on dementia counts toward this requirement. In all probability the area Alzheimer Association training would count toward this requirement as would other training of other community groups. The best way to determine if training meets this standard is to call the sponsoring group for the training or the trainer and ask about the curriculum development and delivery.

Standard 700.B.1

Question: Does this requirement for 2 staff include while the residents are sleeping?

Answer: Yes.

Standard 700.B.4

Question: Do administrators who have been such for a number of years need to have the 12 hours training for assisted living care residents?

Standard 700.B.4 (continued)

Answer: Yes. Within one year of issuance of the license for Assisted Living Care.

Standard 700.B.5

Question: Curriculum for cognitive impairment training shall be developed by a "qualified health professional". Please define qualified - is this a RN or must the RN have background in working with cognitively impaired?

Answer: A qualified health professional is one who is knowledgeable in the area. The person may be an RN, but there are other health professionals who might also qualify.

Standard 700.B.7-11

Question: When do these building requirements such as door monitors, secured outdoor area, etc. become effective? Do we get a grace period to implement?

Answer: All standards became effective 2-1-96. If you do not currently meet assisted living criteria, a residential license could be modified later. Although there is no established grace period, compliance plan could note when corrective action would be complete.

Standard 700.B.9.

Question: Would locks that prevent the windows from being opened enough for a resident to crawl through present a problem in regard to exiting the building in the event of fire or other emergency?

Answer: Before installing any protective devices on bedroom or bathroom windows of residents, licensees should consult with the local building official. This consultation is necessary because Section 1010.4 of the BOCA National Building Code/1993 requires that every sleeping room below the fourth story in occupancies in Use Groups R and I-1 shall have at least one operable window or exterior door approved for emergency exit or rescue. The units shall be operable from the inside without the use of special knowledge, separate tools or force greater than that which is required for normal operation or rescue. Bars, grilles or screens placed over emergency escape windows shall be releasable or removable from the inside without the use of a key, tool or force greater than that which is required for normal operation of the window. Other requirements apply to occupancies in Use Group I-2.

Question: Standards state protective devices on windows in bedrooms, bathrooms, and "common" areas. In the August 21, 1995 Virginia Register - page 3918 which is part of the item #30 "protective devices on windows to limit the devices to bedroom and bathroom" DOES NOT INCLUDE COMMON AREAS! Which is it?

Answer: Final regulations were published in the Virginia Register on December 11, 1995 and included common areas.

February 1997

Standard 700.B.9

Under Standard 700.B.9, the response given in the December 1996 Technical Assistance Insert replaces the first response given under the same standard in the May 1996 Insert.

August 1997

Standard 700.B.1

Question: During the night, can one of the direct care staff members be awake and one asleep?

Answer: Both of the direct care staff members must be awake at all times. Should a facility believe that circumstances warrant allowing one of the staff members to be asleep at night, an allowable variance may be requested.

March 1998

Standard 700.B.3

Question: Does the dementia training taken as part of Standard 630.C.4 also count for Standard 700.B.3?

Answer: As the ALF Direct Care Staff Training outline and curriculum are written for Standard 630.C.4, it does not cover the content and time requirements in Standard 700.B.3. If the following conditions are met, then the training taken as part of Standard 630.C.4 can count for Standard 700.B.3:

1. the ALF Direct Care Staff Training is expanded and lengthened to cover all of the content outlined in 700.B.3,

2. the dementia/cognitive impairments portion of the ALF Direct Care Staff Training is at least four hours, and

3. all of the other content on residents with special conditions in the ALF Direct Care Staff Training are covered adequately.

It should be noted that it is not possible to cover all of the required content in Standard 700.B.3 as well as all of the other required content under residents with special conditions in the ALF Direct Care Staff Training in the suggested 8 hours.

October 2001

Standard 700 C.1

Issue: The trainer from the Alzheimer's Association stated that there was no such thing as a "primary diagnosis of dementia."

Answer: This is language used in the Code of Virginia as it relates to special care units in ALFs. The Alzheimer's Association has been asked to omit this statement when presenting their training to assisted living providers since it conflicts with language in the Code and can be confusing for providers.

Question: May a nurse practitioner or physician assistant complete the assessment?

Answer: In the definition section (10) of the standards, the definition of licensed health care professional has a note that states, "responsibilities of physicians contained within this chapter may be implemented by nurse practitioners or physician assistants as assigned by the supervising physician and within the parameters of professional licensing." If a nurse practitioner or physician assistant implements the responsibilities of physicians as provided in this note, the other provisions of the standard would still have to be met.

Question: Are we expecting everyone with a primary "psychiatric" diagnosis to be followed by a mental health professional?

Answer: No, the standards do not require this.

Standard 700.C.2

Question: Will there be a model form for the written approval?

Answer: Yes. Model form, "Approval for Placement in Special Care Unit" [032-05-082] also includes information on following the order of priority.

Question: If the resident's wife was not willing to give written approval, but allowed an adult child to give written approval for the resident to be admitted to a special care unit and then the wife changes her mind and wants the resident moved out of the unit, can she override the adult child's decision?

Answer: Yes.

Question: What if two adult children disagree over giving the written approval?

Answer: As long as the facility has the written approval from someone in the correct order of priority, the approval is valid. The facility would only have to discharge the resident from the special care unit if someone higher in the order of priority disapproves of the continued placement in the special care unit.

Standard 700.C.6

Question: Must all activity categories listed be included in each week's activities?

Standard 700.C.6 (continued)

Answer: Yes.

Standard 700.C.12

Question: May the staff person responsible for the management of the structured activities program be one of the two direct care staff in the unit?

Answer: Yes, as long as the person meets the requirements of this standard.

Standard 700.C.22

Issue: Building officials have approved locked doors in assisted living facilities located in residential use group buildings. These buildings do not house residents with serious cognitive impairments due to dementia who cannot recognize danger or protect own safety/welfare.

Answer: The Virginia Uniform Statewide Building Code does allow locking devices on the doors of a single family dwelling in a residential use group building. A building official may have approved or will approve such locking devices in an assisted living facility located in a residential use group building.

However, according to the Standards and Regulations for Licensed Assisted Facilities, ONLY facilities that meet the requirements of 700 C may have locked doors (doors that are not readily opened from inside the building without the use of a key or special knowledge) in a special care unit. So a facility with a mixed population may not have locked doors (even though the building official has given his approval).

December 2001

Standard 700.B

Question: Can a "mixed population" include a resident who has a primary psychiatric diagnosis of dementia who cannot recognize danger/protect self?

Answer: Yes.

Question: Does the resident with a diagnosis of dementia in a mixed population have to have a physician's assessment?

Answer: No.

Standard 700.B.1

Question: A facility has a 4th floor that houses a mixed population, does not have "locking devices" on the doors/elevators from the floor, has "wanderguard" monitors on exits/elevators from the floor. Are two direct care staff required on such floors or only two staff in the building at all times?

Answer: Two direct care staff are required in the building, but the ALF must assure appropriate staffing to meet the needs of the residents as required by 22 VAC 40-71-130.

Question: If an ALF has only one resident with a serious cognitive impairment, are two direct care staff required in the building at all times?

Answer: Yes, if it has been determined that the resident cannot recognize danger/protect self.

Question: If a facility has only residents with serious cognitive impairments who CAN recognize danger, are a minimum of 2 direct care staff members required to be in each building?

Answer: It would be rare for a facility to have only residents with serious cognitive impairments who CAN recognize danger, but if that is the case, 2 direct care staff persons are NOT required in each building. The ALF must assure appropriate staffing to meet the needs of the residents as required by 22 VAC 40-71-130.

Standard 700.B.7

Question: In a mixed population, what if SOME but not all doors in the mixed population area are locked at night with a magnetic lock? Those doors can be opened using a keypad or emergency button (labeled "push to exit"), and the doors open automatically if the fire alarm is triggered. Other doors leading to the outside from the same area are NOT locked. Would this be acceptable? (There is a separate safe, secure unit on the third floor.)

Answer: This would not be acceptable. 22 VAC 40-71-275 states "doors leading to the outside shall not be locked…." The keypad and the emergency button are locks.

Standard 700.B.7 (continued)

Question: A facility with a mixed population has a system in which residents with serious cognitive impairments who cannot recognize danger/protect self wear bracelets that trigger a lock when they go near a door. Would this be acceptable?

Answer: This would not be acceptable. 22 VAC 40-71-275 states "doors leading to the outside shall not be locked…." If the bracelet triggered a delayed egress mechanism, this would be acceptable because a delayed egress mechanism is not a lock.

Question: What constitutes a door alarm? Must it be audible in a particular place?

Answer: The alarm can be any device audible to the staff person responsible for monitoring the alarm.

Standard 700.B.9

Question: If an ALF has only one resident with a serious cognitive impairment who cannot recognize danger/protect self, must there be protective devices on all the windows?

Answer: No, only on that resident's bedroom and bathroom windows and on windows in common areas accessible to that resident.

Standard 700.B.12

Question: Should silverware be locked up? Should pre-setting the table be prohibited?

Answer: This depends on the characteristics of the resident population and the amount of staff supervision. If a resident has exhibited behavior that indicates that silverware or dinnerware may be used in a harmful manner, it is the responsibility of the ALF to recognize the risk and take the appropriate measures to eliminate the danger.

Question: "When there are indications…." Does this mean the resident has to have actually demonstrated behavior in which ordinary materials or objects have been misused? What if a resident has a history of aggressive behavior?

Answer: If the resident has a history of behavior or has made statements indicating that ordinary objects or materials may be used in harmful ways, these objects or materials shall be inaccessible except under staff supervision.

Standard 700.C

Question: Does the exception for facilities licensed for 10 or fewer residents apply to special care units?

Answer: The exception does not apply to a special care unit, but does apply to a facility with a mixed population.

Standard 700.C (continued)

Question: Does a special care unit require a separately designated manager?

Answer: No.

Question: Can a safe, secure environment (special care unit) have a mixed population?

Answer: No, a facility that represents itself to the public as having a special care unit must comply with the requirements of 700 C. Special care units may only house residents with serious cognitive impairments due to a primary diagnosis of dementia who cannot recognize danger or protect their own safety and welfare. (See exception on page 66 of 03/03 standards.)

Standard 700.C.1

Question: What is meant by "primary" psychiatric diagnosis? Does that mean it must be the first diagnosis listed? If there are several diagnoses, which one is primary?

Answer: The primary diagnosis is the diagnosis given the greatest amount of attention when a particular intervention is being proposed. For example: A resident with a serious cognitive impairment due to mental retardation has been diagnosed with Alzheimer's Disease. The resident has begun to wander due to dementia and needs a safe, secure environment. The primary psychiatric diagnosis is dementia since it is due to this diagnosis that an intervention is necessary.

Question: If a community physician is medical director for the nursing home unit of a retirement facility and also the personal physician for some of the assisted living residents, may this physician complete the physician's assessment?

Answer: No, the physician does not meet the definition of independent physician.

Question: Can the independent physician be the medical director if he is not paid by the facility?

Answer: Even if not paid by the facility, he may be receiving indirect compensation. Any ALF with this situation must consult with the Regional Licensing Administrator.

Question: Is it necessary to document that the physician completing the assessment has the appropriate qualifications?

Answer: No. However, if the ALF has reason to question the qualifications of the physician, the facility needs to follow up.

Question: Is it acceptable for a facility to use its own form for the physician's assessment?

Answer: Yes, as long as it contains the required information.

December 2001

Standard 700.C.2

Question: Do residents who are capable of making an informed decision have the right to choose if they want to reside in the mixed population or in the secure unit for personal reasons (i.e., because they feel more secure and they can come and go as they wish due to having the code to the keypad)?

Answer: Residents have the right to choose where they want to reside, but special care units are for residents with a primary psychiatric diagnosis of dementia who cannot recognize danger or protect their own safety and welfare. If there are compelling special circumstances, the ALF may request an allowable variance to allow other residents to reside in the special care unit (see exception on page 66 of 03/03 standards).

Question: Is a person with power-of-attorney a "legal representative"?

Answer: Yes, if the resident has granted the power-of-attorney the authority to make decisions about the person's residence.

Question: Where would power-of-attorney fall in the priority list? For example, if one adult child had power-of-attorney, would that child's approval take precedence over another adult child's disapproval of a parent's placement in a special care unit?

Answer: The power-of-attorney who has been granted authority to make such a decision by the resident is a legal representative and would take precedence over an adult child without the power-of-attorney. To avoid conflicts, the facility may want to see a copy of the power-of-attorney to ensure this authority has been granted.

Question: Would an "adult child" include a stepchild?

Answer: No, unless the resident has legally adopted that individual. A stepchild has no legal relationship to the resident.

Question: What if the person who pays the bill and the person who has highest priority according to the standard do not agree about the resident's placement in a special care unit? How does a facility balance those interests?

Answer: According to the standard, the person with the highest priority may give the written approval. If the person who pays the bill will not pay, the facility must decide whether or not to accept or retain the resident.

Question: The spouse is higher that the physician on the list of priority for the written approval. What if the spouse is confused?

Standard 700.C.2 (continued)

Answer: The standard stipulates that a "relative who is willing and able to take responsibility to act as the resident's representative" may give the written approval for placing a resident in a special care unit. If the spouse is confused and not able to take responsibility to act as the resident's representative, the facility needs to document how it was determined that the spouse was unable to give the approval.

Standard 700.C.5

Question: When doing the review, what if one of the persons to be consulted is unavailable?

Answer: The facility should be able to demonstrate efforts made to contact the person, but if the individual truly is unavailable, it is not expected that he would have to be consulted in order to complete the review.

Standard 700.C.12

Question: What if residents from more than one special care unit are routinely combined for activities – would each special care unit be required to have an activities manager for 20 hours per week?

Answer: The standard requires that the person managing the activities be in the special care unit 20 hours per week. That time does not have to be spent solely on activities nor does the person need to actually conduct the activities. The person managing the activities needs to spend 20 hours per week with the residents from each special care unit so the manager is aware of the residents' needs and abilities. If, for example, the residents of two units were combined for activities, the time the activity manager spent with the residents would count toward the 20-hour requirement on each unit.

Standard 700.C.22 (and 700.B.7)

Question: In the past, facilities have been allowed to install a security monitoring device such as Wanderguard on one floor only, as long as that floor contains all required area/programs for residents (common areas, activity program, etc.) Would such a facility now be required to install security monitoring on EXTERIOR doors instead, or would its existing safeguards meet the requirements of the standard?

Answer: Doors leading to the outside from areas housing a mixed population and from a special care unit must be monitored. This may be a mechanical system or through constant staff oversight.

If all residents with serious cognitive impairments who cannot recognize danger/protect own safety are always on the floor with the security monitoring system on the doors leading from that floor, it is not necessary to have a security monitoring system on the doors on floors where no residents with serious cognitive impairments who cannot recognize danger/protect own safety reside.

Section 54.1-3408, Code of Virginia

Question: What is the definition of controlled substances? Does this mean any medication which cannot be purchased over the counter, any prescribed medication?

Answer: In Virginia, a controlled substance is any medication which requires a physician's prescription.

Section 54.1-3408.01, Code of Virginia

Question: The law specifies staff of assisted living facilities shall not call in oral prescriptions on behalf of practitioners. Does this refer to staff who are not trained professionally or to all staff whether or not medically trained?

Answer: Oral prescriptions may be transmitted to the pharmacy by the prescriber or an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber. If staff of an ALF meet this definition, they may call in oral prescriptions. CNAs, medication aides, and other staff not meeting this definition may not call in oral prescriptions.

March 1998

Section 54.1-3408, Code of Virginia

Question: Section 54.1-3408, Code of Virginia, regarding the administration of vaccines, prohibit a LPN from administering a vaccine if a RN is not present?

Answer: Yes.

August 1997

Auxiliary Grants Program (AG)

Question: Why are some residents on auxiliary grants receiving $40 allowance while others are receiving $60?

Answer: Some people have earned and unearned disregards (of their income other than AG such as SSA, workshop earnings, etc.). The unearned disregard is $20.

Question: Are incontinence care products covered by the auxiliary grant rate?

Answer: AG regulation states that the grant covers "minimal assistance with ... care of needs associated with menstruation or occasional bladder or bowel incontinence." This could be construed to mean that ALFs would provide products for occasional incontinence.

Question: if the family of a resident receiving an auxiliary grant is unable to provide incontinence products is the facility required to provide them?

Answer: The ALF does not have to provide incontinence products on a prolonged basis.

Question: Does AG pay for incontinence diapers? If not, is the assisted living facility responsible for paying for them? (We have heard that Medicaid will pay for them.) Can the facility use resident spending money for these? (Will get expensive.)

Answer: No, AG does not cover purchase of incontinence diapers for prolonged incontinency. Medicaid may pay if approved by the Department of Medical Assistance Services (DMAS). A facility may not use a resident's spending money for these - a facility may bill the resident who would pay for the incontinence supplies.

October 1998

Auxiliary Grants Program

Question: Should the extra Department of Medical Assistance Services (DMAS) money be reported on the auxiliary grant cost report as income?

Answer: Yes. Both regular assisted living and intensive assisted living revenue received from DMAS for assisted living facility (ALF) residents enrolled in the Auxiliary Grants Program should be reported on Schedule D ("Operating Revenue and Expenses, - page 7, line 3) of the ALF-98 Cost Report.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

December 14, 2001

TO: Assisted Living Facility Administrators
Department of Social Services' Licensing Staff

FROM: Carolynne H. Stevens, Director
Division of Licensing Programs

SUBJECT: Questions and Answers on Standards for Licensed Assisted Living Facilities

Attached is a copy of some questions and answers on the Standards and Regulations for Licensed Assisted Living Facilities and also one clarification on § 63.1-182.1 of the Code of Virginia as it relates to assisted living facilities. This is the second document issued recently containing clarifications on these standards. The first document was included in the October 2001 "Information and Technical Assistance for Adult Providers."

If you have questions about these clarifications, please contact your regional licensing inspector.

CHS/khc

Attachment

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: May 6,1999

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your manual entitled "Technical Assistance for Licensing Staff - On Adult Care Residence Regulations." The material is that which appeared in the most recent quarterly mailing, dated April 27, 1999, to adult care providers. It has been reformatted to fit into your manual under the appropriate standard numbers. The notation "April, 1999" is found in the upper right corner to identify the date the material was included with the quarterly mailing. Please insert these new pages in the proper places in your notebook.

c: Lib Whitley Baron
Jane Brown
Rhonda Harrell
Margie Marker
Sandra Mosley
Doris Sherrod
Terry Smith
David Stankavich
Carolynne Stevens
Kathryn Thomas

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: October 20, 1998

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your manual entitled “Technical Assistance for Licensing Staff - On Adult Care Residence Regulations.” The material is that which appeared in the most recent quarterly mailing to adult care providers. It has been reformatted to fit into your manual under the appropriate standard numbers. The notation “‘October, 1998” is found in the upper right corner to identify the date of the material. Please insert these new pages in the proper places in your notebook.

c: Lib Whitley Baron
Jane Brown
Rhonda Harrell
Margie Marker
Doris Sherrod
Terry Smith
David Stankavich
Carolynne Stevens
Kathryn Thomas
Kittie Winston

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: July 17, 1998

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your manual entitled "Technical Assistance for Licensing Staff - On Adult Care Residence Regulations." The material is that which appeared in the most recent quarterly mailing to adult care providers. It has been reformatted to fit into your manual under the appropriate standard numbers. The notation "July 1998" is found in the upper right corner to identify the date of the material. Please insert these new pages in the proper places in your notebook.

c: Lib Baron
Jane Brown
Rhonda Harrell
Margie Marker
Doris Sherrod
Terry Smith
David Stankavich
Carolynne Stevens
Kathryn Thomas

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: April 10, 1998

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your manual entitled “Technical Assistance for Licensing Staff - On Adult Care Residence Regulations.” The material is that which appeared in the quarterly mailing, dated March 30, 1998, to adult care providers. It has been reformatted to fit into your manual under the appropriate standard numbers. The notation “March 1998” is found in the upper right corner to identify the date the material was included with the quarterly mailing. Please insert these new pages in the proper places in your notebook.

c: Lib Baron
Jane Brown
Rhonda Harrell
Margie Jernigan
Doris Sherrod
Terry Smith
David Stankavich
Carolynne Stevens
Kathryn Thomas

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: August 8, 1997

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your "Technical Assistance for Licensing Staff - On Adult Care Residence Regulations" manual which you received in January at the training session for adult program staff. The material is that which appeared in the technical assistance insert to *The Standards Bearer, Volume 9, Number 2, August 1997*. It has been reformatted to fit into your manual under the appropriate standard number. The notation "August, 1997" is found in the upper right corner to identify the date the material appeared with *The Standards Bearer.* Please insert these new pages in the proper places in your notebook.

c: Christine Antonelli
Lib Baron
Terence Bethea
Jane Brown
Rhonda Harrell
Margie Jernigan
Doris Sherrod
Terry Smith
Carolynne Stevens
Carolyn Sturgill
Kathryn Thomas

VSS
PEOPLE HELPING PEOPLE
COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEMORANDUM

DATE: March 26, 1997

TO: Regional Licensing Administrators and Adult Program Licensing Specialists

FROM: Judy McGreal

SUBJECT: Material for Technical Assistance Manual

Attached is additional material for your "Technical Assistance for Licensing Staff' manual which you received in January at the training session for adult program staff. The material is a combination of that which appeared in *The Standards Bearer, Volume 9, Number 1, February 1997* under the title "Technical Assistance" and in the technical assistance insert to that issue of the newsletter. The material has been reformatted to fit into your manual under the appropriate standard number. The notation "February, 1997" appears in the upper right corner to identify the date the material appeared in *The Standards Bearer.* Please insert these new pages in the proper places in your notebook.

c: Christine Antonelli
Lib Baron
Terence Bethea
Jane Brown
Karen Cullen
Rhonda Harrell
Margie Jernigan
Doris Sherrod
Terry Smith
Carolynne Stevens
Kathryn Thomas